AUDITOR GENERAL

1993/94: REPORT 5

Value-for-Money Audits

MINISTRY OF HEALTH

The Transfer of Patients from Riverview Hospital to the Community

Psychiatrist Services

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The Honourable Emery Barnes
Speaker of the Legislative Assembly
Province of British Columbia
Parliament Buildings
Victoria, British Columbia
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Sir:

I have the honour to transmit herewith my Value-for-Money Report to the Legislative Assembly on:

- The Transfer of Patients from Riverview Hospital to the Community; and
- Psychiatrist Services

Both of these audits were carried out within the Ministry of Health.

George L. Morfitt, FCA
Auditor General

Victoria, British Columbia
May 1994

copy: Mr. E. George MacMinn, Q.C.
Clerk of the Legislative Assembly

Ministry of Health

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Overview

Overview

This report, my fifth to the Legislative Assembly for the 1993/94 year, contains the results of two value-for-money audits that focus on matters pertaining to mental health care in the province.

I last reported on the matters relating to health in my 1989 Annual Report. At that time the focus of our work was hospitals, the Medical Services Plan, continuing care, and public health.

This year our audits consider a different aspect of health: mental health care. The Royal Commission on Health Care and Costs in its 1991 report titled Closer to Home recommended that the Auditor General conduct a value-for-money audit that examined mental health services in the province. In the section of its report dealing with mental health, the Commission identified the downsizing of Riverview Hospital and the provision of psychiatrist services as subjects of interest.

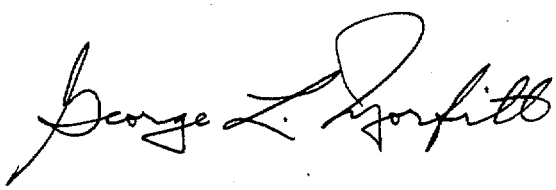
In the first audit in this report, we examine how the ministry has planned the transfer of patients and funding from Riverview Hospital to community-based programs. In the second, we assess how the ministry ensures that psychiatrist services are accessible to persons with serious mental illness in a cost-effective way.

Although these two audits concentrate on different aspects of mental health care, they have some striking similarities. Both focus on the performance of the Ministry of Health in carrying out its responsibilities with respect to mental health care services in the province. However, in both of the areas reviewed, the ministry must work in partnership with others who play a significant part in service delivery.

The transfer of patients from an institutional setting to community-based services involves the British Columbia Mental Health Society which operates Riverview Hospital, as well as those who provide services in the community. Psychiatrist services are provided in various settings by doctors, who are

members of the British Columbia Medical Association, often in accordance with the provisions of a contract with the Medical Services Plan. These organizational arrangements add complexity to the challenge of managing the delivery of mental health care services.

While our audits identified certain aspects of mental health care that might be improved, I am pleased that the ministry is using a consultative approach to bringing about the transfer of Riverview Hospital patients, and that the ministry and the British Columbia Medical Association have recently struck a joint committee to consider the issues involved in making psychiatrist services accessible to the province's citizens suffering from serious mental illness.



George L. Morfitt, FCA
Auditor General

Victoria, British Columbia
April 22, 1994

Introduction

Ministry of Health

Introduction

This report contains the results of two value-for-money audits conducted in the Ministry of Health in 1993. We focused our audits on matters pertaining to mental health care in the province.

Improved treatment methods and the greater emphasis on individual rights have lead to a world-wide trend towards providing care for people with mental illness closer to home. In mid-1985 the ministry began planning how to replace the outdated buildings at Riverview Hospital in Port Coquitlam and how, generally, to improve the province's mental health care system. This work resulted in a plan, published by the ministry in 1987, that called for downsizing Riverview Hospital and shifting from institution-based to community-based services. In the first audit reported here, we examine how the ministry is planning the transfer of patients and funding from Riverview Hospital to the community.

In the second audit, we assess how the ministry ensures that psychiatrist services are accessible to the seriously mentally ill in a cost-effective way. The Ministry of Health's mission is to maintain and improve the health status of all British Columbians and, in so doing, it aims to ensure that both its programs and personnel are equitably and efficiently distributed throughout the province. One important element in meeting this responsibility is to ensure that those with serious mental illness have appropriate access to psychiatrist services when needed.

Ministry responses to all our value-for-money audits are published along with our reports. Over time, as the ministries implement the recommendations that arise from our audits, we publish their accounts of progress in our annual reports. We believe this keeps the legislators and the public informed of the nature, extent and results of ministry remedial actions. We follow up on our audit recommendations when we carry out our next audit of each ministry.

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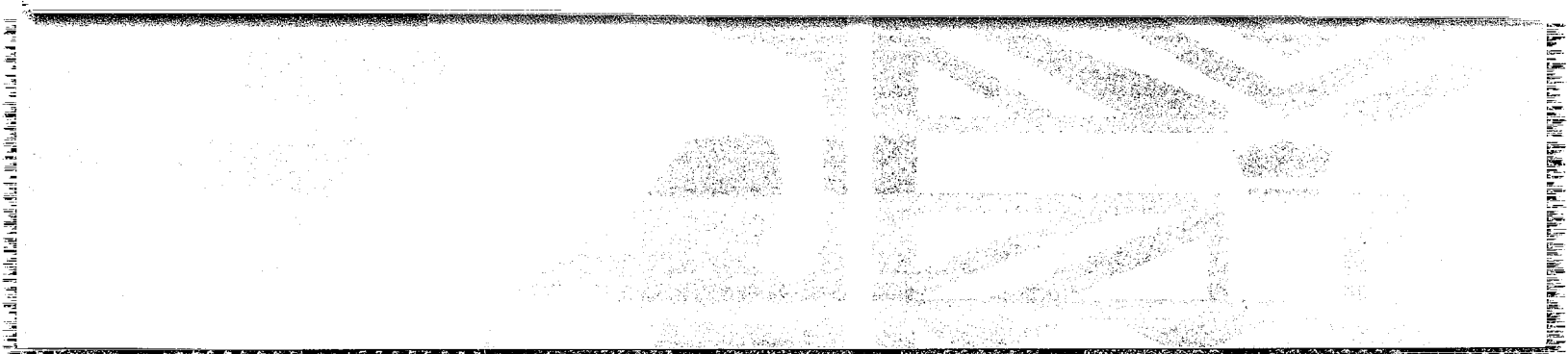
AUDITOR GENERAL

Value-for-Money Audit

MINISTRY OF HEALTH

The Transfer of Patients from Riverview Hospital to the Community



Ministry of Health

The Transfer of Patients from Riverview Hospital to the Community

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Ministry of Health

The Transfer of Patients from Riverview Hospital to the Community

An audit of how the ministry is planning the replacement of Riverview Hospital

In mid-1985, the Ministry of Health began planning how to replace the outdated buildings at Riverview Hospital in Port Coquitlam and how, generally, to improve the province's mental health care system. The results of this work were published by the ministry in 1987, in a report titled the *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital.* The plan outlined in the report called for replacing Riverview Hospital and shifting the balance of the mental health care system in the province from institution-based to community-based services.

In February 1990, the government announced the Mental Health Initiative, described as an endorsement of the Mental Health Consultation Report. It included a promise of a $20 million increase in annual funding to address critical service shortages in mental health care.

In late 1991, the British Columbia Royal Commission on Health Care and Costs reported that it found general agreement that the policy outlined in the 1987 Mental Health Consultation Report represented an effective and ethical means of moving patients out of institutions while, at the same time, containing costs. It also discovered, however, a feeling that action had not followed the policy described in the report and that the mental health service still lacked an overall plan.

Audit Purpose and Scope

We conducted this audit to assess how the ministry has planned the transfer of patients and funding from Riverview Hospital to community-based programs. We reviewed the transfer of patients that occurred between April 1, 1992, and March 31, 1993—the first year of formal downsizing—to determine whether it had been adequately planned, implemented, and evaluated. As well, we assessed the accountability information that the ministry has

given Members of the Legislative Assembly about the transfer of patients and funding from the hospital to the community.

We did not look at how the routine discharge of patients from Riverview Hospital is managed. Furthermore, we did not review the decision to shift mental health care from an institution-based to a community-based service delivery model, nor did we assess the adequacy of funding for mental health care in the province.

Our examination was performed in accordance with value-for-money auditing standards recommended by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

Overall Conclusion

Between April 1, 1992, and March 31, 1993, as part of the ministry's program to replace Riverview Hospital, 67 patients were moved out of the hospital to smaller facilities in the community—facilities that might be described as "closer to home." Funding was also shifted from the hospital to the community. We concluded that these transfers were adequately planned, implemented, and later evaluated.

Since the government announced the Mental Health Initiative in 1990, the ministry has engaged in an extensive consultation process with mental health care stakeholders. However, it does not yet have a well-documented, comprehensive long-term plan on which a shared understanding of expectations concerning the replacement of Riverview Hospital and related patient and funding transfers can be based, or against which progress can be evaluated.

At the time of our audit the Members of the Legislative Assembly had not yet received information about the transfer of patients and funding from Riverview Hospital to the community.

Key Findings

The Process Used to Transfer Patients in 1992/93 Was Adequate

The Ministry of Health remains committed to the principles set out in the Mental Health Initiative, and has begun to implement the recommendations contained in the Mental Health Consultation Report. The closure of 105 beds at Riverview Hospital and the placement of 67 patients in community facilities in the 1992/93 fiscal year represented the first formal downsizing of the hospital as part of the implementation of the Mental Health Initiative.

Patient needs were matched with community resources

Patients were chosen for transfer to the community through a process that matched each individual's care requirements to the facilities and services available in the community. Patients considered for transfer were interviewed and invited on pre-transfer visits to residential facilities. Efforts were made to include family members in the planning and preparation for transfer.

Almost all the patients transferred in the 1992/93 fiscal year remained in the lower mainland, where there was available residential capacity. It is expected that patients transferred in the future will represent a greater challenge because they will be people who require facilities and services additional to those currently available in the community.

Support systems were developed

A Transitional Assistance Program supported patients making the move from Riverview Hospital to the community. This program enabled staff from the hospital to visit regularly with patients who were transferred, providing them with the comfort of a familiar face during an adjustment period. In addition, patients experiencing a crisis within six months of discharge from the hospital can be readmitted directly to the hospital if necessary.

An information system was developed to permit the ministry to track the progress of patients transferred from the hospital as part of the program. Information is gathered on location, health status, health care services being received, and impact on the facility and other residents.

Resources were shifted from Riverview Hospital to the community

The ministry reduced the 1993/94 fiscal year operational funding of Riverview Hospital by approximately $6 million to reflect the closure of 85 beds in the 1992/93 fiscal year. This money was allocated to the Continuing Care and the Mental Health Services divisions of the ministry. The hospital was allowed to retain money associated with the closure of the other 20 beds to enhance its programs.

The Ministry's Long-Term Planning Needs to Be Improved

The ministry undertook to replace Riverview Hospital as part of its commitment under the Mental Health Initiative to redevelop the mental health care system in British Columbia. The Initiative set out a broad statement of objectives, as well as funding and time parameters.

Since the announcement of the Initiative the ministry has concentrated on developing community resources. This included

increasing semi-independent living units significantly, setting up emergency response teams and outreach teams, and developing community-based multidisciplinary teams.

The planning process is complex but not well documented

An extensive and complex process to plan the replacement of Riverview Hospital has evolved, with numerous committees and a great deal of consultation.

However, there is as yet no well-documented summary of the results of these consultations on which a shared understanding of expectations concerning the replacement of Riverview Hospital can be based. There is no comprehensive plan covering the full scope and time frame of the undertaking. The ministry has not yet determined how much of which services will be required; when, where, and how these services will be created; what resources will be required and how they will be obtained; and how and by whom progress will be monitored and reported.

To date, the ministry's planning for the development of community resources and downsizing of Riverview Hospital has focused on the short term—the current year and next year. It has approached downsizing as a year-to-year iterative process until planning for replacement facilities has been finalized. The ministry states that it is still in the consultation phase of planning and that, until the size and location of replacement facilities have been determined, it is premature to document a long-term plan for the replacement of Riverview Hospital.

An objective method of funding the shift in services has not been finalized

The Mental Health Consultation Report recommended the transfer of money from Riverview Hospital to community-based facilities and programs. It anticipated that more than half of the hospital's funding would be transferred to the community and that management and funding structures would be set up to facilitate development of community resources.

We found that the ministry has not established an objective method of determining the amount of money that will be shifted from the hospital to the community each year. This has created uncertainty for both the hospital and the community. For the first two years of shifting funding from the hospital to the community, the ministry has negotiated with the British Columbia Mental Health Society to establish how much money should be shifted. These negotiations have been challenging, with the Society saying that it cannot give up resources until the cost of providing tertiary care in replacement facilities has been established, and with the community looking to the hospital for money to upgrade services required in the community.

A human resources plan that encompasses the full scope of the replacement of Riverview Hospital has not been finalized

Improvement of the mental health care system by moving to community-based programs requires qualified people to provide services in the community. The ministry must ensure that these resources are available when and where they are needed. Because Riverview Hospital will not require the same level of staffing it has at present, there must also be a plan for reducing hospital staffing from current levels. Although primary responsibility for staffing adjustments at the hospital rests with the British Columbia Mental Health Society, the ministry must be involved in these reductions because employees at the hospital have public servant status.

In the 1992/93 fiscal year, the ministry and hospital worked together to create a Labour Adjustment Strategy for nurses, to facilitate movement of 25 hospital nurses to positions in the community. There are also pilot projects under way to develop a strategy for shifting health care workers from the hospital to the community. However, the ministry has not yet developed a long-term human resource plan.

Any plan that it does develop must be within the context of existing collective agreements.

Information Has Not Been Provided to the Legislative Assembly

Members of the Legislative Assembly have not been provided with information about the transfer of patients and funding from Riverview Hospital to the community.

The Mental Health Care System

The British Columbia mental health care system serves the needs of people with mental illness in the province. These are people with diagnoses that include schizophrenia, psychosis, organic brain syndrome, and major affective disorders such as manic depression. Usually there is a disability arising from the illness, which leaves the affected individual with a partial or total inability to meet normal responsibilities in social, work, and home settings.

The prevalence of mental illness in our society is relatively high. Knowledgeable observers agree that 3-5% of all people, at any one time, are afflicted with a serious mental illness. It has been further estimated that up to 20% of people, at any one time, are affected by personal, family, or situational difficulties which cause them to seek assistance in the mental health system.

In the past, many people with mental illness experienced medium- to long-term hospitalization. Over the last 40 years, however, more people who previously would have been institutionalized have been able to remain in community-based programs. There are several reasons for this change: improvements have been made in pharmaceutical technology and in psychotherapy, rehabilitation, and patient management methods; there has been considerable development of community housing and support services; the law governing the involuntary treatment of persons with mental illness has changed, such that the rights of individuals must be more carefully balanced with their need for treatment.

Underlying the move to community-based treatment are two beliefs. The first is that treatment and care can be provided in community programs and facilities for all but those persons with the most severe disabilities. The second is that persons with mental illness should be united as much as possible with their families, friends, and local community environments so that the "normalization" approach—the foundation of mental health rehabilitation programs—is reinforced.

The mental health care system reflects a historical emphasis on institutional care. To successfully shift the emphasis to community-based mental health care requires further development of support services that can enable a person with mental illness to function in a community setting. This means providing individuals with access to housing in the form of group residential facilities or semi-independent living arrangements in apartments and houses. It means providing individuals, who are experiencing crises but who do not require hospitalization, with access to specialized services and facilities. And it means providing individuals who need tertiary care—care requiring highly specialized skills, technology, and support services—with access to such care.

A Short Glossary of Terms

The **British Columbia Mental Health Society** is responsible for the operation of Riverview Hospital. It gives direction to the administration of the hospital through the hospital's President and Chief Executive Officer. Riverview Hospital is both a hospital in Port Coquitlam and an organization providing care for persons with mental illness.

The **British Columbia Royal Commission on Health Care and Costs** produced the *Report of the British Columbia Royal Commission on Health Care and Costs* (also called "Closer to Home") in 1991.

The **Mental Health Consultation Report** refers to the *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital*, published by the Ministry of Health in 1987.

The **Mental Health Initiative** is the name given to the Government's commitment, announced in February 1990, to implement the recommendations contained in the Mental Health Consultation Report and to provide additional funding to improve the community mental health care system.

Community care, in contrast to "institutional care" refers to care provided for persons with mental illness through residential facilities and services that are available outside Riverview Hospital. Some of these facilities and services are provided through mental health centres run by the Ministry of Health, and some are provided by other organizations.

Replacement of Riverview Hospital includes both downsizing and decentralization of the present hospital and the shifting of mental health care from institutional to community-based services.

Deinstitutionalization refers to the decreasing dependence on psychiatric hospitals as the location for the treatment of persons with mental illness, and the development of alternative facilities and services in the community.

Downsizing refers to the reduction in the number of long-term psychiatric hospital treatment beds in the province to 550 from approximately 1,220.

Decentralization refers to the planned distribution of psychiatric hospital treatment beds to several locations in the province. At present, all of these beds are located at Riverview Hospital.

Riverview Hospital

Riverview Hospital in Port Coquitlam is one of the oldest hospitals in British Columbia. It was established in 1913 as an asylum for seriously mentally ill persons. Since that time, it has been the province's main treatment, rehabilitation, and asylum center for adult and elderly people with serious and disabling mental illnesses. By 1956, it had more than 4,300 patients. From the early 1960s to the present,

however, changes in mental health care have progressively reduced patient numbers to a current level of fewer than 1,000. Several of the buildings at Riverview Hospital have been closed and are awaiting demolition.

Exhibit 1.1 shows the changes in beds and staffing that have occurred at the hospital since the publication of the Mental Health Consultation Report in 1987.

During the period 1988 to 1994, the number of beds at Riverview Hospital has been reduced by 350. During the same period, staffing levels fluctuated. In 1989/90, additional staff were hired when the Society undertook the development of community operations at the request of the ministry. These operations were later transferred to the ministry. The Society reduced the number of staff positions by 94 in the 1992/93 fiscal year; a further reduction of 89 is scheduled for the 1993/94 fiscal year.

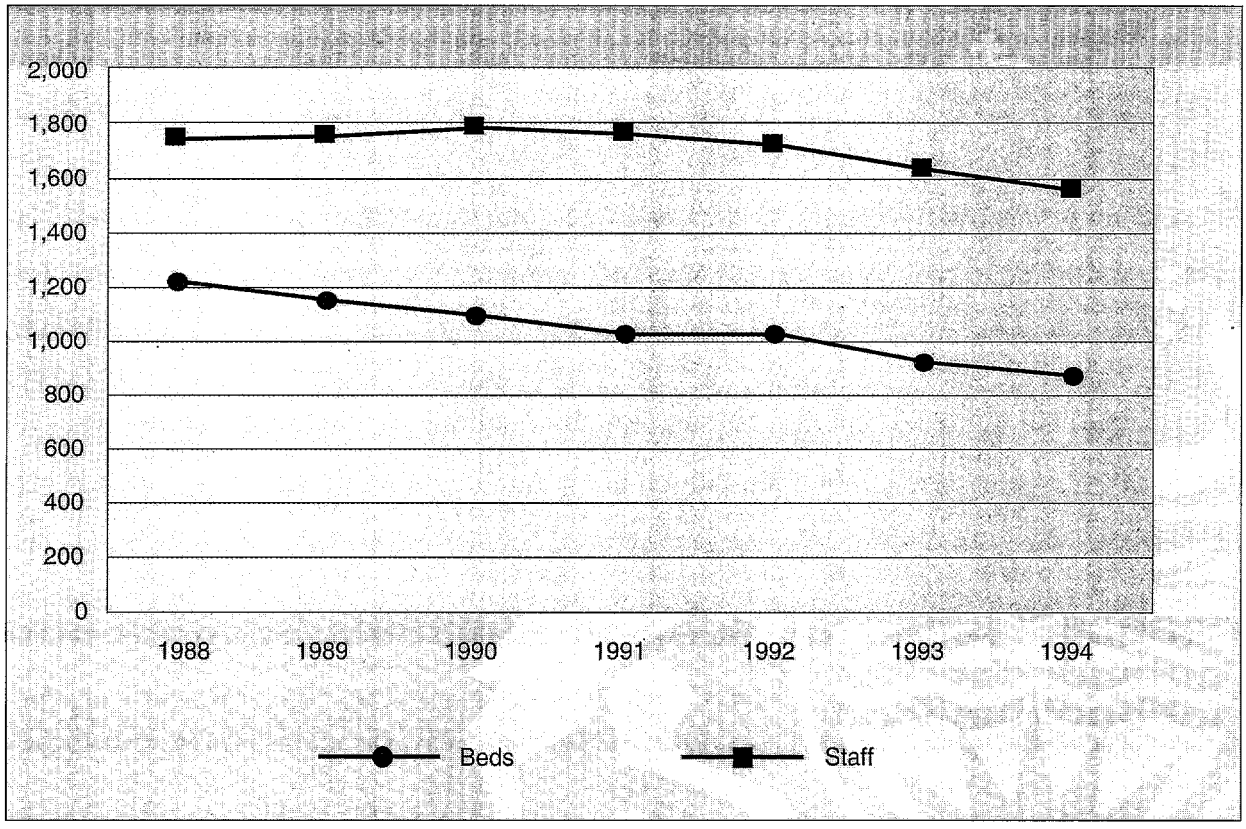
The British Columbia Mental Health Society

In December 1987, the provincial government

Exhibit 1.1

Riverview Hospital Beds and Staffing

At March 31, 1988 to 1994



Source: British Columbia Mental Health Society

incorporated the British Columbia Mental Health Society to operate a hospital "for the care and treatment of mentally disordered persons." The bylaws of the Society stipulate that all members will be appointed by the Minister of Health. All of the Society's original members and, during the first five years of its existence, a majority of its members, were employees of the Ministry of Health. Although the Society is independent from the ministry, it is dependent on the ministry for its funding and the members of the Society are required to manage it in a manner that is "not inconsistent with [the] policies of the Provincial Government."

In 1987, the government approved the transfer of Riverview Hospital operations from the Ministry of Health to the Society. The government's Estimates for 1988/89 show that the effect of this transfer was to reduce the number of employees in the ministry by 1,671. Although employees were transferred from the employ of the ministry to that of the Society, they continued to be recognized as public service employees for collective bargaining purposes.

During the late 1980s and early 1990s, the Society made plans for an expanded role in the delivery of mental health care services. It also developed and funded a number of community-based programs. By the 1991/92 fiscal year, approximately 6.5% of the operating grant to the Society was allocated to funding community-based service initiatives. The Society also helped the ministry respond to staffing and funding restrictions by loaning staff to the ministry.

In January 1992, the ministry requested the Society to concentrate its efforts on the management of Riverview Hospital and development of new specialized hospital facilities required to provide tertiary psychiatric services in various regions of the province. The ministry also asked the Society to continue helping with the development of new community-based mental health care programs. Those programs are to be developed jointly, then turned over to local administering agencies as soon as they can manage the additional responsibilities.

In August 1992, the Society appointed a new Chief Executive Officer followed, two months later, by the appointment of a new, larger Board of Trustees—intended to provide a broader representation of society in general and of the various regions of the province. No ministry employees currently sit on the Board of Trustees.

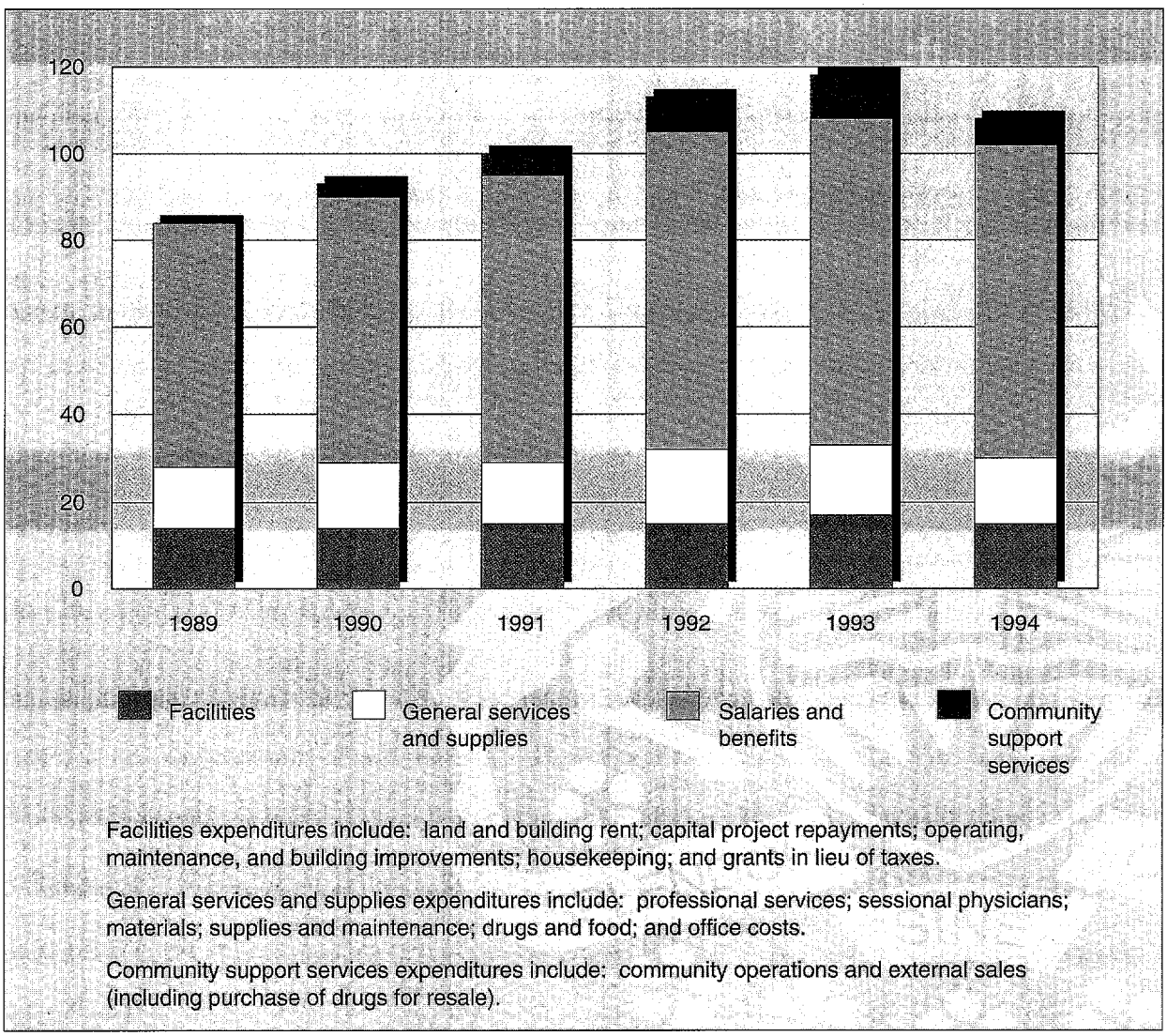
In March 1993, the Society approved a revised mandate, values, mission, and goals statements to reflect its recently clarified role. The mandate states that the Society "is responsible for the operation of Riverview Hospital" and, in the context of the Mental Health Initiative, "the Society will operate Riverview Hospital throughout the functional planning and bed reduction processes." It goes on to say that "the Society will work with the community mental health care system to develop corresponding beds and services in the community and to implement the transfer of patients and services to community-based programs."

Exhibit 1.2 shows the funding of the Society for the fiscal years, 1988/89 to 1993/94. The major increases in funding over the past four years have gone to government-negotiated wage settlements. During the fiscal years 1989/90 to 1992/93, the hospital was funded to run community-based programs. In 1993/94, funding for those programs, and for beds closed as patients were transferred to the community, was removed from the Society's budget. The Society still supplies support services to the community on a cost recovery basis.

Exhibit 1.2

British Columbia Mental Health Society Expenditures

For the fiscal years March 31, 1989 to 1994 ($ Millions)



Facilities expenditures include: land and building rent; capital project repayments; operating, maintenance, and building improvements; housekeeping; and grants in lieu of taxes.

General services and supplies expenditures include: professional services; sessional physicians; materials; supplies and maintenance; drugs and food; and office costs.

Community support services expenditures include: community operations and external sales (including purchase of drugs for resale).

Source: British Columbia Mental Health Society

As delivery of mental health care services in the province is shifted from being institution-based to being community-based, fewer people will be admitted to Riverview Hospital. At the same time, those patients who are able to be moved will be transferred to community-based care. In this way the capacity of the hospital can be reduced, in keeping with the recommendations contained in the Mental Health Consultation Report.

The Mental Health Consultation Report

In 1984, the Ministry of Health received government approval to plan for the replacement of Riverview Hospital. The ministry did an internal review of all mental health care services in the province to ensure planning for the replacement of the hospital was integrated with the development of the rest of the mental health care system.

The review indicated that the future needs of people with mental illness in British Columbia would be better served by more services being provided in the community. It recognized that if mental health care services are to be effective, the consumers of those services should be involved in service planning. Research has shown that what health care professionals think is needed may not necessarily be what patients think is needed. Furthermore, the nature of mental illness is such that many individuals with the greatest need are unwilling to receive treatment, because they consider it an unattractive alternative to their illness. For these reasons, a full public consultation process was seen as the best way to develop and implement a sound service plan.

In mid-1985, this consultation began with the circulation, to interested parties, of preliminary proposals for the future of Riverview Hospital and the mental health care system. Submissions were received from many professional, labor, institutional, educational, and service provider groups. In addition, many persons with mental illness, their families, and their advocates were asked for their input. The results of this consultation process were published in 1987 in the *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital.*

The report outlined a plan for improving the existing mental health care system to meet the needs of adult and elderly persons with serious mental illness. It called for a move to community-based treatment, with psychiatric units in general hospitals providing acute care to all but the most difficult patients. The latter, the report recognized, would not benefit from the proposed community-based programs. Instead, those patients would require medium- to long-term treatment, rehabilitation, and protective asylum. The report therefore also proposed that facilities to care for such patients be part of the plan to replace Riverview Hospital.

As well as containing a number of recommendations, the report included a fiscal strategy for implementation. It recommended that the current level of financial

resources at Riverview Hospital be made available for the treatment, rehabilitation, and support of mentally ill people transferred to community-based facilities and programs. At that time, the level of funding at the hospital for the treatment and rehabilitation of its patients was $73 million. The plan recommended reassigning those resources as follows:

	$ Millions
Medium-and long-term psychiatric beds	34.1
Emergency and short-term psychiatric beds	5.7
Family support services (general practitioners, psychiatrists, case management/treatment)	15.9
Community support programs	7.3
Community residential care	10.0
Total	**73.0**

According to the report, the existing level of funding would be required to replace services currently provided to patients at the hospital. The shift to community-based facilities and programs was not expected to result in savings. The rationale for the shift was based on quality of care rather than on economic efficiency.

Given the experience of other jurisdictions, the report recommended that replacement facilities and programs be established in community settings before any reductions or adjustments to existing facilities and programs at Riverview Hospital took place. It called for "bridge" funding to be made available, to permit the development of community-based facilities and programs while Riverview Hospital was gradually being scaled down.

A five-year implementation period was proposed, to begin from the point of Cabinet approval of the plan. Approval was not obtained until January 1990.

The report received strong endorsement from patients, the public, and the providers of mental health care services. Support was based on two conditions, however: first, that additional resources be provided to meet a shortfall existing between service capacity and critical service requirements; and second, that adequate transitional funding be provided to permit development of community-based programs and facilities before the replacement of Riverview Hospital.

The Mental Health Initiative

In February 1990, the government announced the Mental Health Initiative, which was described as an endorsement of the principles and philosophy articulated in the Mental Health Consultation Report. Representing a long-term strategy for the replacement of Riverview Hospital, it included two interdependent initiatives. The first was improvement of community-based services. The second was replacement of Riverview Hospital with hospital and community residential beds.

The premise of the Initiative was that better mental health care can be delivered "closer to home" than through institutional care in a

large centralized psychiatric hospital. It called for providing care in the community using several smaller regional psychiatric hospitals in combination with residential facilities, short-term crisis facilities and services, and outpatient services. It also called for the introduction of a mix of hospital inpatient and community-based outpatient services, which in total would equal the 1,220-bed service that had been provided at Riverview Hospital for the same operating cost required to maintain the hospital's operations. This would be accomplished by creating 670 inpatient psychiatric beds (consisting of 170 acute care psychiatric beds in general hospitals and 500 medium-to long-term psychiatric hospital beds in specialized facilities throughout the province) and 550 community residential beds, as well as community support services.

The Initiative proposed other changes as well. It called for extending the five-year implementation period in the Mental Health Consultation Report to 10 years. It called for increasing the Mental Health Services Division annual funding by $20 million, phased in over several years, to address critical service shortages. That funding was intended to provide for development of community-based support services including up to 20 additional medical specialists, 175 additional community-based mental health personnel, 500 community residential beds, and 750 activity and vocational training spaces. As well, the Initiative called for providing $2.6 million per year for 10 years to fund transition costs and the development of services and facilities in the community before replacement of Riverview Hospital began. It also approved $60 million in capital funding for new facilities.

In keeping with the spirit of the Mental Health Initiative, the ministry has developed additional community housing resources. Exhibit 1.3 shows the increase in housing, by type, offered to adults with serious mental illness.

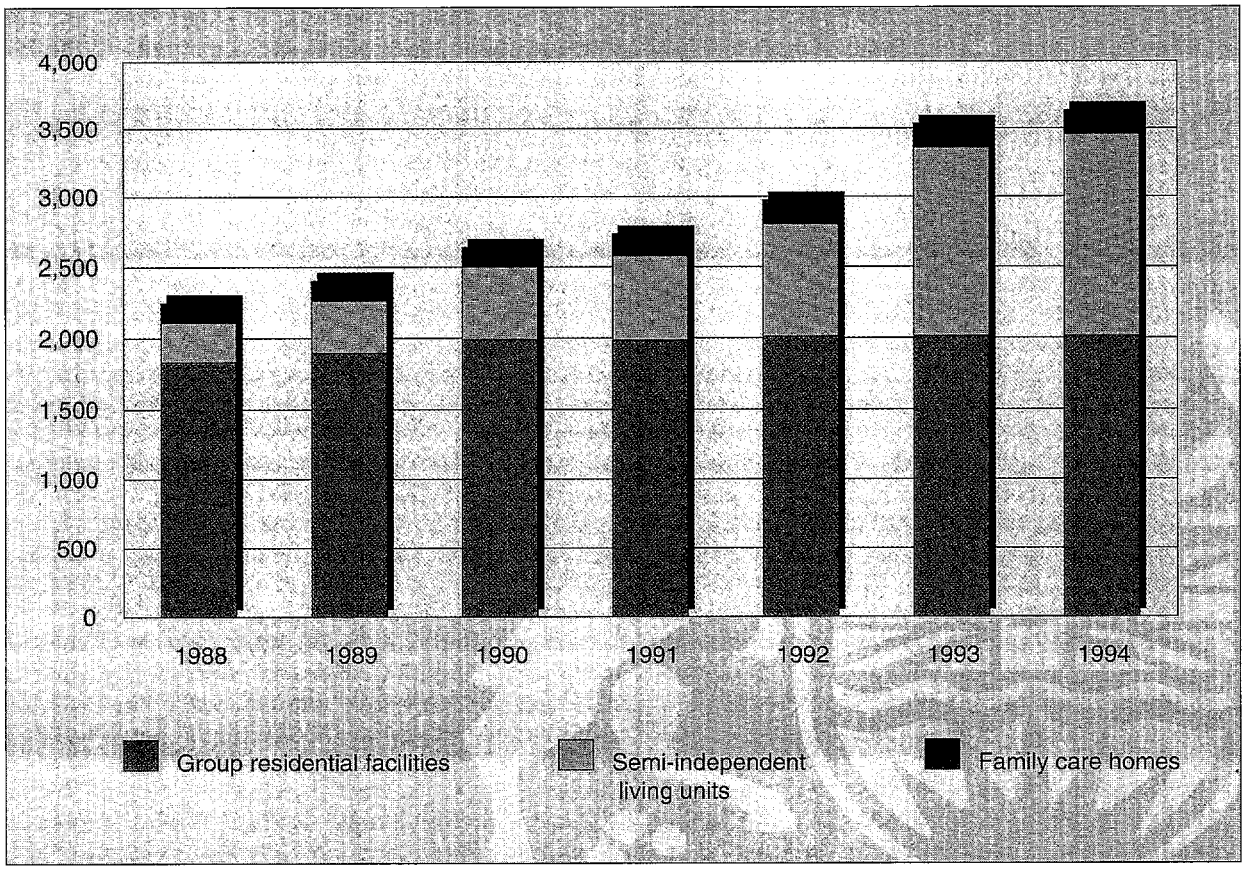
The Ministry of Health has developed over 1,150 additional semi-independent living units since 1988. These are supported or assisted community living arrangements enabling adults to live in self-contained housing units with the help of outreach support services. Group residential facilities still form the bulk of the specialized housing for people with mental illness. They vary in size from 3 to 42 beds and are operated by private and non-profit agencies, and offer full-time care. Family care homes are privately owned family-style homes operated by an individual or a family. A maximum of two patients can live in a family care home at one time.

In keeping with the plan outlined in the Mental Health Consultation Report, patients were to be transferred to community-based care as beds were closed at Riverview Hospital. The resources required to provide for their care in the community were to be transferred from the hospital as the patients were transferred.

After the Mental Health Initiative was announced, the ministry began planning for its implementation. The ministry

Exhibit 1.3

Types of Community Residential Housing Provided by the Ministry of Health
At March 31, 1988 to 1994 (Units)



Source: Ministry of Health

prepared plans outlining preliminary annual development targets and estimated the financial implications of the proposed bed closures and development of community-based facilities and services.

Royal Commission on Health Care and Costs

The Royal Commission on Health Care and Costs was established in 1990 with terms of reference that directed it to examine:

- the structure, organization, management, and mandate of the current health care system in British Columbia;
- the utilization, appropriateness, and efficacy of health care services; and
- the costs associated with each of the health care system's major elements.

In 1991, the Commission published a report of its work. It found general agreement that the policy outlined in the 1987 Mental

Health Consultation Report represented an effective and ethical means of moving patients out of institutions while, at the same time, containing costs. It also discovered, however, a feeling that action had not followed policy described in the report and that mental health service still lacked an overall plan.

The Commission observed that, "for a reduction of the Riverview Hospital facility to be accomplished, target dates must be established and new tertiary facilities built in the districts expected to provide regional services to mentally ill people." It noted that neither detailed plans to accomplish the downsizing nor interim measures to implement it had been developed.

In its recommendations, the Commission suggested that the Ministry of Health, "in its role as coordinator and consultant . . . develop multi-year plans and priorities through consultation with community advisory boards . . . ." It went on to say, "[If] there is to be further deinstitutionalization, then more money will be needed to fund community services. The government must maintain its commitment to the $20 million enhancement initiative begun in 1990, but the rationale for that money, and the government's specific objectives, must be defined. To date, the government has not provided any assurances that the enhancement monies are either needed or sufficient."

As the Mental Health Consultation Report and the Royal Commission found, the redevelopment of the mental health care system—including the replacement of Riverview Hospital—is a significant undertaking. In the following section, we report on the results of our review of the process used for transferring patients and funding to the community and downsizing the hospital in the 1992/93 fiscal year.

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Transferring Patients to the Community in 1992/93

The closure of 105 beds at Riverview Hospital and the transfer of patients to the community in the 1992/93 fiscal year represented the first formal downsizing of the hospital as part of the implementation of the Mental Health Initiative. Given the significance of the Initiative to the future of the mental health care system in British Columbia, the ministry had an interest in ensuring the process used for the first year's transfers was effective and efficient.

We expected the ministry to ensure that the transfer of patients from the hospital to communities in the 1992/93 fiscal year was well managed. To this end, we looked for monitoring and evaluation of transfers, and for integration of the results of evaluation into planning for subsequent years' transfers.

We also examined the following factors we believed were critical for an adequate transfer of patients:

- identification of patients who were best suited for care in the community and assessment of their needs for residential facilities and mental health care services;
- review of residential facilities and services for people with mental illness in the community before patients were transferred from the hospital;
- assessment of quality of life of patients transferred to the community;
- assessment of the transfer process used in the 1992/93 fiscal year and integration of the results of the assessment into planning for transfers in subsequent years; and
- transfer of funding from the hospital to the community following the closure of beds at the hospital.

Conclusion

We found that the transfer of patients from Riverview Hospital to the community in the 1992/93 fiscal year was adequately planned, implemented, and evaluated. Funding was also shifted from the hospital to the community.

Ministry staff, hospital staff, and private sector care providers worked together to facilitate placement of 67 patients in a range of community facilities. Ministry staff believe the process worked as well as it did because of the tremendous commitment and efforts of the individuals involved.

Findings

Identifying Patients Best Suited for Care in the Community

The patients that have been transferred from the hospital as part of the replacement of Riverview Hospital were moved from a large institution to smaller facilities that are "closer to home" both geographically and socially.

Each year, there are approximately 1,000 admissions to Riverview Hospital. Most of these patients stay for only a short period

before they leave the hospital and return to live, more or less independently, wherever they were living before admission to the hospital. Our audit did not deal with planning for the discharge of these patients. We looked at planning for the transfer of a relatively small group of patients, most of whom had lived at Riverview Hospital for a number of years and who could not reasonably be expected to live in the community independently.

Determining Which Patients Would Be Transferred

The thesis of the Mental Health Consultation Report was that mentally ill persons should be reunited as much as possible with their families, friends, and local community environments in order to reinforce the whole "normalization" effort underlying mental health rehabilitation. In keeping with this, we expected there would be a systematic approach to determining which patients were capable of living outside the hospital and where they should be moved.

We found that patients were chosen for transfer to the community on the basis of needs assessment data available in hospital records and assessments made by community-based care providers. This information identified the requirements of patients and described the facilities and services that were available in the community. Most of the patients identified for transfer in the 1992/93 fiscal year were those who were at Riverview Hospital because adequate facilities and support services had not been available in the community at the time they were admitted.

The ministry and the hospital staff recognized that, to ensure a smooth transition, patients and their families had to be involved in the planning and transfer. This support was particularly important to gain because some of the patients had been at Riverview Hospital for a long time and did not want to leave. As well, some family members had expressed concerns about the downsizing of the hospital.

Patients considered for transfer in the 1992/93 fiscal year were interviewed by community service providers and had an opportunity to have pre-transfer visits to the intended destinations.

Assessing Individual Needs of Patients

Patients transferred from Riverview Hospital to the community need essentially the same range of services as was available to them at the hospital. They need access to medication, case management, affordable housing, vocational opportunities, community acceptance, recreation, and adequate financial resources. For many of them this means they need to be able to live on the level of income provided by social assistance, supplemented by the Ministry of Health for rental subsidy and work incentive programs.

As a precondition to any patients being transferred to the community, staff at Riverview Hospital committed to assessing all patients at the hospital and making placement plans for each one, either in the community or at

the hospital. In April 1992, staff began creating the Patient Needs Assessment database—a systematic assessment of patient needs—for all patients at the hospital. This information is available to assist the ministry in the development of services for patients who are being transferred to the community.

Treatment plans have been developed for all patients in Riverview Hospital. These plans provide a record of treatment, describing problems and the best approach for dealing with them. Sometimes these plans have to be modified to accommodate changes in patient behavior after a patient moves into community facilities.

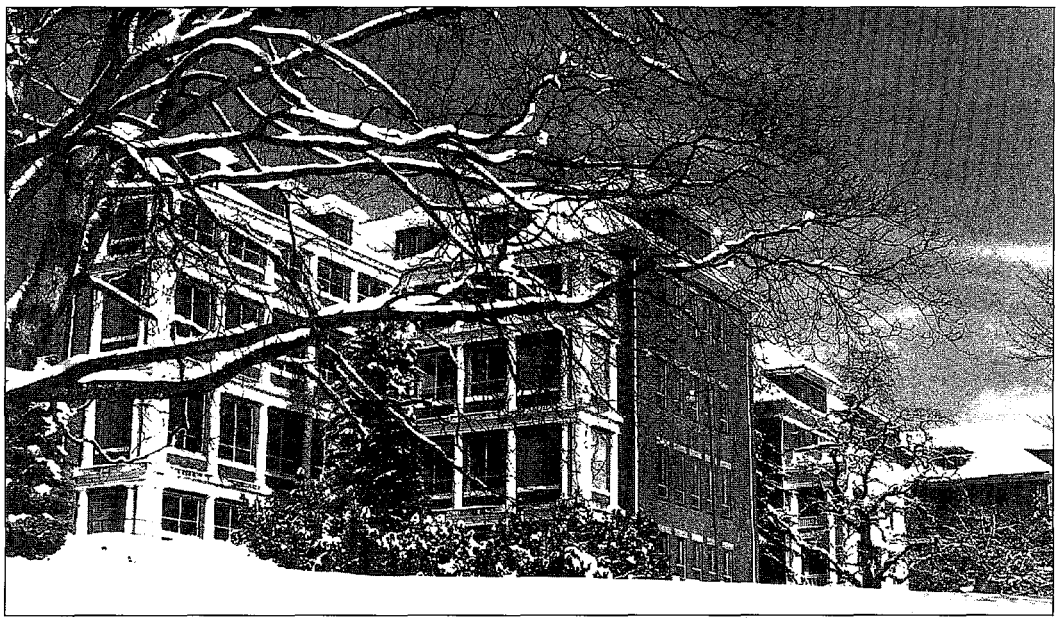
Assessing Services in the Community

Almost all the patients transferred in the 1992/93 fiscal year went to the Fraser Valley/North Shore region of Mental Health Services Division. They were individuals who were from the Fraser Valley, or had friends or relatives in the area, or who had no desire to return to the location from which they had been admitted to Riverview Hospital. The Fraser Valley/North Shore region was able to make existing suitable residential capacity available into which these patients could be moved.

The choice of patients for transfer to the community in the 1992/93 fiscal year was based not only on the ability of patients to live in the community, but also on the availability of suitable facilities. Riverview Hospital had originally proposed the transfer of a group of patients requiring special facilities. After consultation between the hospital and the ministry, it was agreed that the transfer of these patients should be deferred to a later date when appropriate community housing and support services had been developed for them.

Providing Care in the Community

After patients have been transferred to the community, it is important to monitor how well they adjust to the new



Courtesy of British Columbia Mental Health Society

Riverview Hospital

environment. Riverview Hospital has developed a Transitional Assistance Program to provide patients with support before and after they move from the hospital to the community. Through the program, staff from the hospital help patients and care providers during the transition period. Staff provide additional services to the patients up to one month before their discharge from the hospital and six months after. If a patient experiences a crisis during the first six months after discharge, he or she can be admitted directly back to the hospital if necessary.

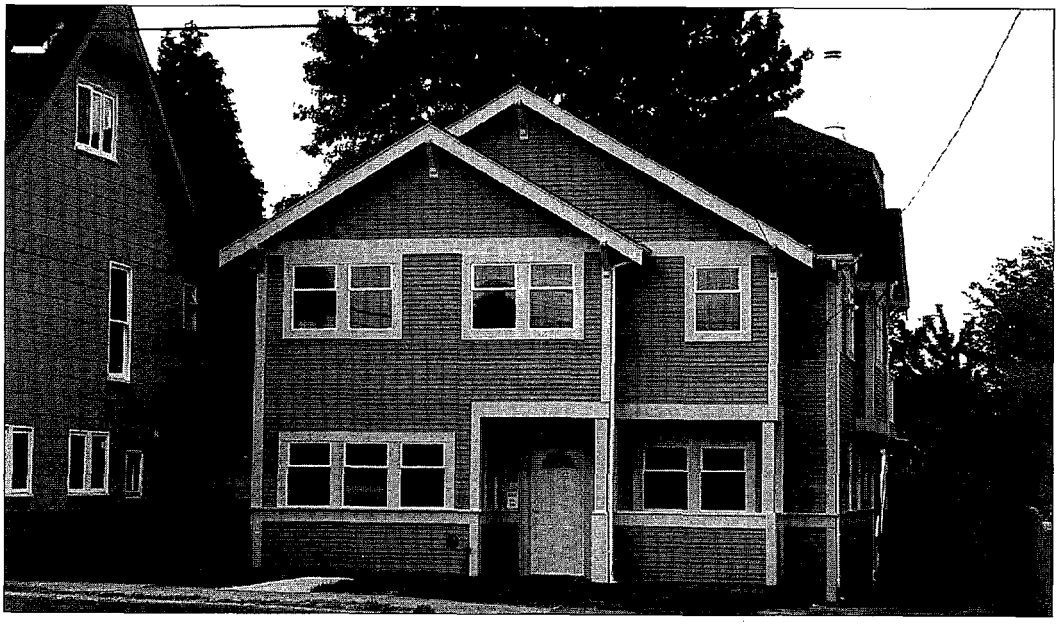
A tracking project has followed the patients transferred in the 1992/93 fiscal year since their discharge. The return-to-hospital rate for this group is lower than average. The Transitional Assistance Program may be a factor, as well as the better monitoring of patients in the community.

Monitoring Quality of Life

Patients transferred as part of the downsizing of Riverview Hospital have gone mostly to group residential facilities funded by the ministry. The ministry has a right—and a responsibility—to monitor how well patients are doing in these facilities.

The Patient Tracking Project was developed to permit the ministry to monitor patients transferred from the hospital as part of the replacement process. It provides information on patient location, health status, health care services received, and impact on facilities and other residents.

Because the ministry is unable to monitor most discharged patients, it has limited means to compare patients who are discharged with those who are transferred as part of the replacement process. Most patients return to the larger community, where their right to



Courtesy of Ministry of Health

Six bed group residential facility for people with chronic mental illness. Care is provided 24 hours per day and consists of meals, housekeeping, supportive counseling and rehabilitation.

privacy takes precedence over any medical interest that might be served by an intrusive monitoring program.

Improving the Process

Planning for the closure of beds and transfer of patients from Riverview Hospital to the community has been under way for several years, but the patient transfers in the 1992/93 fiscal year were the first transferred as part of the current phase of the replacement process. Because more of these transfers are planned for the future, we expected the ministry to have monitored the process to ensure that opportunities to improve the process were identified and integrated into planning for subsequent years.

Following the 1992/93 fiscal year transfers and bed closures, both Riverview Hospital and the ministry conducted informal evaluations of the process used to manage the transfers. These evaluations resulted in proposals for improvements to the transfer process.

The focus for planning the 1993/94 fiscal year transfers has shifted from Riverview Hospital to the community. In the 1992/93 fiscal year, planning for the year's transfers began with the hospital identifying the patients who were to be transferred and the ministry attempting to find room for them in the community. This proved to be difficult in some instances and, in the end, the hospital and the ministry worked together to match patients who could be transferred

A Better Medical Information System Is Needed

A significant difficulty with deinstitutionalization and the maintenance of persons with severe mental illness in the community is that such individuals, when experiencing a crisis requiring medical intervention, are often unable to provide medical personnel with a coherent history of their illness, diagnoses, and past treatments.

The same holds true for other people who, arriving at emergency wards, are in a condition that precludes them from providing information about their medical history. There are also people who visit more than one physician or who change physicians frequently. These patients are sometimes unable or unwilling to provide a record of their medical history.

In all of these situations, medical personnel must work with a serious lack of information or they have to replicate work that may have been done already. This poses a risk to both patient and medical personnel, as well as an added cost to the health care system.

We believe the ministry should investigate the development of an electronic medical information database for all participants in the provincial health care plan.

We recognize this is a complex matter with medical, legal, social, and financial implications, but we believe that the potential benefits of such a system warrant its consideration.

with facilities available in the community.

In the 1993/94 fiscal year, the Provincial Planning Committee, made up of representatives from the ministry, the Greater Vancouver Mental Health Services Society, and Riverview Hospital, is taking the lead in planning. The committee will determine the ability of the community to take patients and will work with the hospital to identify suitable candidates for transfer to the community.

Shifting Funds to the Community

In every province in Canada, although people with serious mental illness spend most of their time in the community, nearly all of the resources are located in institutions. Shifting mental health care service systems from an institution-based to a community-based model requires a significant reallocation of funding and human resources.

The Mental Health Consultation Report recommended that the financial resources at Riverview Hospital be available to fund the operation of both replacement tertiary care facilities and the treatment, rehabilitation, and support of mentally ill people transferred to community-based facilities and programs. Implementation of the report's recommendations was to involve reallocating resources from the hospital to the rest of the mental health care system. It was planned that once replacement facilities and programs were in place in the community, using "bridge" funding, then funds could be shifted from the hospital to the community to pay the cost of operating community-based facilities and programs on an ongoing basis.

The ministry negotiated with the Society to determine how much money was to be shifted from the hospital to the community. The ministry, in deciding the amount of funding reallocation, had to consider conflicting arguments. The Society argued that it should be entitled to retain some of the funds saved by bed closures to improve existing services or develop new ones. Community representatives argued that funds should be made available to improve community-based services in general, not just to provide services to patients transferred from Riverview Hospital.

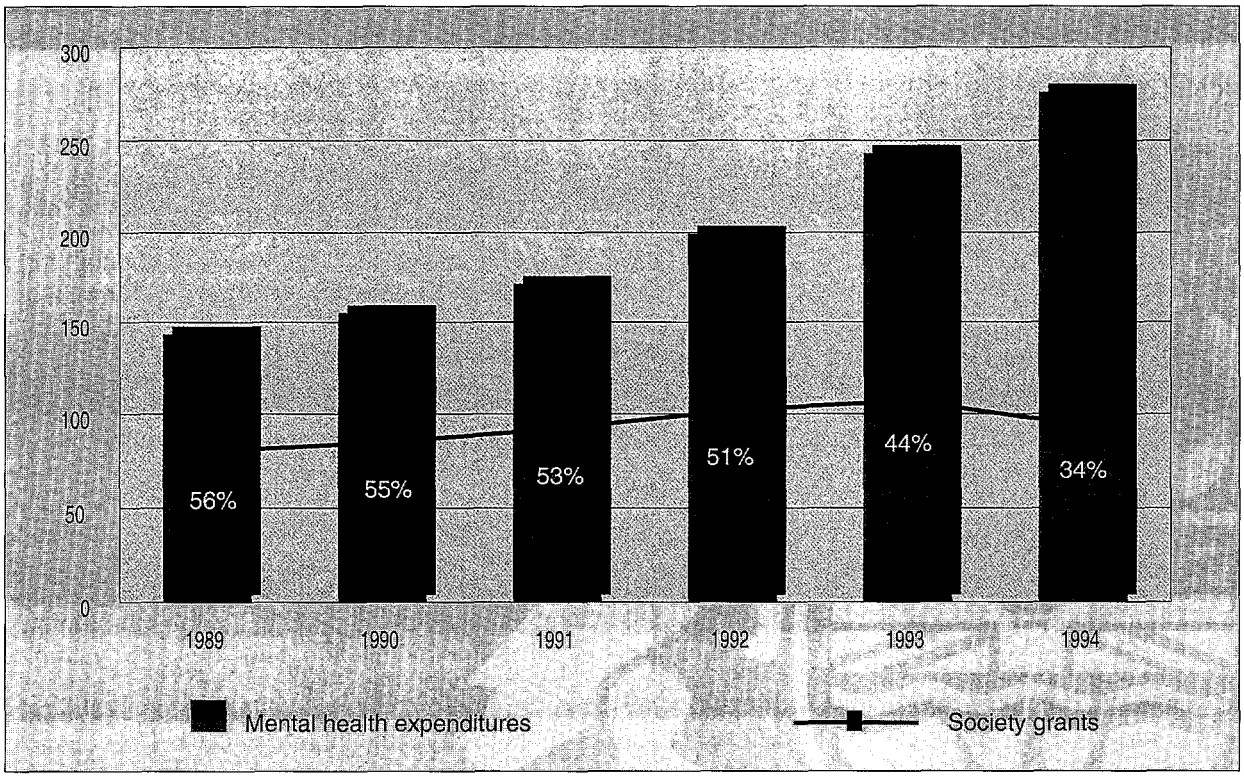
We found that the ministry has reduced funding for the operation of Riverview Hospital in the 1993/94 fiscal year by approximately $6 million to reflect the closure of 85 beds in the previous year. The savings associated with closure of the other 20 beds are being retained by the hospital to be reinvested in its programs.

In reallocating that $6 million, the ministry has increased the budget of its Continuing Care Division by $2.4 million in the 1993/94 fiscal year to reflect the transfer of patients from Riverview Hospital to Continuing Care facilities. The Fraser Valley/North Shore region of the Mental Health Services Division received an extra budget allocation in the 1993/94 fiscal year of $3.1 million to develop new community-based services; and the Vancouver Island region received $0.4 million.

Exhibit 1.4

Comparison Between British Columbia Mental Health Society Grants and Mental Health Expenditures

For the fiscal years March 31, 1989 to 1994 ($ Millions)



Sources: British Columbia Mental Health Society and Ministry of Health

Exhibit 1.4 shows the mental health budgets for 1989 to 1994 and the grants paid to the British Columbia Mental Health Society during the same period. During this time, the grants to the Society have decreased as a percentage of expenditures on mental health from 56% in 1988/89 to a proposed 34% in the 1993/94 fiscal year.

The patients in that first transfer were relatively easy to accommodate, and they were transferred mostly into existing community facilities. In the future, however, many of the patients transferred will likely require facilities and services in addition to those currently available in the community. The process to ensure that those facilities and services are available will be more complex than that required in the 1992/93 fiscal year.

In addition to assessing the patient transfers for the 1992/93 fiscal year, we also reviewed the ministry's long-term plan for the transfer of patients to the community as part of the replacement of Riverview Hospital. The following section of the report presents our findings.

Long-term Planning for Replacement of Riverview Hospital

Shifting the delivery of mental health care services from an institution-based to a community-based model is a major undertaking for the ministry. To carry out the change over the proposed 10-year period, we expected the ministry to assume a lead role in ensuring that system-wide planning occurs. We looked for it to have an appropriate process with which to plan the transfer of patients and funding from Riverview Hospital to communities.

Because most of the funding for the development of community-based facilities and services is to come from Riverview Hospital, the ministry must ensure that the replacement of the hospital is coordinated with the development of community-based facilities and services. This requires a shared understanding of expectations. We looked for a comprehensive long-term plan documenting objectives, significant policies, responsibilities, implementation strategies, timetables and target levels of achievement, funding implications, evaluation procedures, and reporting mechanisms.

Conclusion

Since 1990, the ministry has engaged in an extensive consultation process with mental health care stakeholders and has gained experience from the patient and funding transfers that occurred in the 1992/93 fiscal year. However, the ministry does not yet have a well-documented, comprehensive long-term plan on which a shared understanding of expectations concerning the replacement of Riverview Hospital can be based. We believe the ministry needs to improve its planning by developing a long-term plan—with clear statements of objectives, implementation strategies, timetables and target levels of achievement, resource requirements, and provisions for periodic evaluation and reporting on progress—and communicating it to all stakeholders.

Findings

The Planning Process

The ministry is reshaping the province's mental health care system with the replacement of Riverview Hospital and development of facilities and services in the community. Given the significance and cost of this undertaking, we expected the ministry to clearly define its role in managing the long-range planning and coordination within its own organization, with other ministries, and between it and non-public service organizations over the 10-year implementation period.

During 1990 and 1991, when most of the trustees of the Society were ministry employees, the ministry delegated to the British Columbia Mental Health Society the responsibility for planning the implementation of the Mental Health Initiative. The intention was to develop new services outside ministry operations, in

keeping with the government's policy at that time. In early 1992, responsibility for the strategic planning function was transferred back to the ministry.

We expected the ministry, once it resumed the responsibility, to plan both the short- and long-term strategies for translating the vision of an improved mental health care system into reality.

Since the announcement of the Mental Health Initiative in 1990, the ministry has focused its planning for development of community resources and downsizing of Riverview Hospital on the short term—the current year and next year. The ministry sees shifting the delivery of mental health care services from an institution-based to a community-based model as an iterative process. To date, it has focused on year-to-year budgeting, with implementation based on available funds.

The ministry has, however, approached the planning for Riverview Hospital replacement facilities with a long-term focus. Conceptual planning for these facilities is now under way.

Input from Stakeholders

The Mental Health Consultation Report recommended that the consultation process continue during the implementation in order to ensure that local priorities and needs for mental health care services are addressed. The professional literature on shifting from institution-based to community-based delivery of mental health care services backs up this recommendation.

The ministry recognizes the importance of involving all the stakeholders in the planning process. To facilitate communication and consultation in support of planning, it has created the Mental Health Implementation Steering Committee (an interministry committee with representatives from Health, Social Services, and Attorney General) and the Provincial Mental Health Advisory Council (with representation from patients' and family members' groups). The ministry has also set up the Provincial Consumer Advisory and the Provincial Family Advisory councils, and has encouraged the formation of similar groups at regional and local mental health centre levels.

In addition to an organized planning process, we expected the ministry to have a formal plan that clearly describes what will be done, when, by whom, and what the financial implications will be.

A Long-Term Plan

To ensure that the shift in services and funding is carried out efficiently and effectively, the ministry needs an implementation plan to determine what facilities and services must be developed, in which locations, and at what time. It has to identify lead times for planning, designing, and building facilities; it has to spell out staffing requirements and strategies for recruitment and training; and it has to determine funding needs. It should also monitor progress, evaluate achievement or variance, and regularly update the plan.

A plan can be a single document or it can be a number of

documents, each consisting of one or more elements of the plan. In our opinion, a single integrated planning document would be preferable and probably more efficient.

We were unable to find any plan covering the full scope of the project. We did find some of the elements of a plan, but nothing that was comprehensive.

The Mental Health Initiative announced in February 1990 included a broad statement of objectives, as well as funding and time parameters. The Initiative called for the implementation, over a 10-year period, of the recommendations of the Mental Health Consultation Report, plus an increase in base budget funding for mental health care services, to be phased in over the first three years of the implementation period.

In late 1991, the British Columbia Mental Health Society wrote to the ministry expressing concern about the absence of a clearly articulated plan for bolstering the community infrastructure and network of services. The Society was clearly concerned about how the lack of an enhanced community infrastructure might affect its ability to proceed with the hospital's redevelopment. The hospital has prepared its own strategic plans for redevelopment, but these are contingent on outside developments. The uncertainty surrounding the extent and timing of transfers and funding reductions makes it difficult for the hospital to develop its plans and to communicate with patients, family members, and employees.

In 1992, the Mental Health Services Division prepared the Strategic Mental Health Plan (1992), which outlined a general strategy to be followed in the 1992/93 fiscal year and over the next five years. It identified 13 significant issues that the ministry believed had to be dealt with as part of the development of mental health for the future. For each issue, one-year and five-year objectives were stated in both narrative and quantitative terms. There was no analysis of the funding implications of the plan, however, nor a detailed implementation schedule.

The Strategic Mental Health Plan (1993) is an update of the 1992 plan, describing in narrative form the various mental health care services that the ministry funds. Although it outlines mental health policy goals, special initiatives, and core services of the ministry's mental health programs, it does not contain specific goals for any period.

We believe the ministry needs a comprehensive implementation plan for the Mental Health Initiative. This plan should describe:

- the specific objectives of the Initiative;
- an implementation strategy for how those objectives will be achieved;
- a timetable and target levels of achievement;
- a funding strategy; and
- a human resource strategy.

Some of these elements have been partly dealt with by the ministry, as described below.

Project Objectives

The objectives of the Mental Health Initiative are clear. The ministry wants to move the mental health care system toward more and better community-based programs, replace Riverview Hospital, and develop additional specialized facilities in selected regions throughout the province. Exactly how these objectives will be achieved is less clear.

Implementation Strategy

The ministry has set some short-term priorities in support of the shift from institution-based mental health programs to community-based programs. These include substantially increasing semi-independent living units, setting up of emergency response teams and outreach teams, and developing community-based multidisciplinary teams.

However, the ministry has not yet developed long-term plans that identify how much of which services will be required; when, where, and how these services will be created; what resources will be required and how they will be obtained; how progress will be monitored and by whom; how

What Mental Health Care Services Are Required in a Community

The professional literature makes numerous references to failures of deinstitutionalization that were attributable to inadequate community-based services. The ministry has committed to developing services to meet the needs of patients from the hospital before patients are transferred.

According to a leading Canadian authority on the delivery of community-based mental health care services, the following community support services are needed for patients with severe mental illness: patient identification and outreach, mental health treatment, health and dental services, crisis services, housing, income support, peer support, family and community support, rehabilitation services, protection and advocacy services, and case management. These service requirements may vary from community to community. Given the size of British Columbia and the differences in population patterns throughout the province, it is clear the same range and level of mental health care services cannot be made available to all residents of the province. However, identifying which services are needed, and where, is difficult because of the significant differences of opinion among stakeholders about what the mental health care system should look like in any particular community.

Without standards, or even a clear definition of "community", the ministry is not able to describe what services should be available or what level of accessibility to those services is reasonable. Although the ministry has some facility and service "benchmarks" based on mental illness prevalence studies, these require further development before they can be accurately used for planning mental health care services regionally or locally.

direction and control will be applied to care providers; and what accountability reporting will be required.

Timetable and Target Levels of Achievement

The Mental Health Initiative was specific about what facilities and services were to be provided as part of the Initiative. It established goals for new community residential beds, spaces in rehabilitation programs, case managers and outpatient treatment staff, and additional psychiatrists. It also proposed to use resources made available as part of the replacement of Riverview Hospital over 10 years to fund acute psychiatric beds in general hospitals, specialized psychiatric inpatient beds, and additional community residential beds with associated rehabilitation programs and case managers.

Following public announcement of the Initiative, a draft schedule dated October 1990 established targets for bed replacements and bed closures for fiscal years 1991/92 through 2000. There were targets for facility and service development, as well as a schedule outlining the financial implications of these targets. The schedule was last updated in December 1990.

Funding Strategy

The Consultation Report included a fiscal strategy for the transfer of financial resources from Riverview Hospital to community-based facilities and programs. It anticipated the eventual transfer of more than half of the hospital's funding to the community and indicated that management and funding structures would have to be developed to facilitate redevelopment of resources.

The draft schedule, dated December 1990, does contain a 10-year proposal for shifting operating funds from the hospital to the community and the replacement facilities. What is not clear is how the appropriate level of funding to be shifted in each year is to be calculated. There is no objective method for determining the amount of money that should go to the community from the hospital as a result of bed closures.

For the first two years of shifting funding from the hospital to the community, the ministry has negotiated with the British Columbia Mental Health Society to decide how much money to shift from the hospital to the community. These negotiations have been challenging. The Society is concerned that it cannot give up the level of resources initially contemplated in the Consultation Report and still deliver adequate tertiary care. It believes that the total cost of operating the replacement tertiary care facilities (as called for in the Consultation Report) must be established before the amount of funding for transfer from the hospital to the community can be determined. This has not yet been done.

Planning for replacement tertiary care facilities is under way, but has not yet reached the point where operating costs can be estimated accurately. Naturally, until then, the Society wishes the ministry to adopt a conservative

approach to reducing its funding. The community, on the other hand, has been looking to Riverview Hospital for money to upgrade basic services. Some stakeholders are concerned that there will not be enough resources that can be shifted from the hospital to achieve the objectives of the Mental Health Initiative.

The Consultation Report identified the need for "bridge" funding to develop community-based facilities and programs while Riverview Hospital is gradually being scaled down, and to support existing operations until the replacements are ready.

The Mental Health Initiative contained provision for $2.65 million per year for 10 years to fund transition costs, including community education and staff retraining. The intended use of these funds was $2.1 million annually for operating the existing and replacement services concurrently, and $0.5 million annually for planning and contingencies. No transition funding was provided to the ministry before the 1992/93 fiscal year, when it spent $1.8 million.

Human Resource Plan

Implementation of the Mental Health Initiative can occur only if adequate numbers of qualified staff are available throughout the province to provide needed services. Since Riverview Hospital will no longer require the same level of staffing currently in place, a plan must be devised for reducing and redeploying current staff.

PLANNING FOR DECENTRALIZATION

At the same time the ministry is developing community-based programs and transferring patients from Riverview Hospital to community-based facilities, it is planning for the decentralization of hospital-based services for mentally ill people.

The Mental Health Consultation Report recommended the development of up to 550 beds in small units for medium- or long-term psychiatric inpatient care in strategic locations in the province. The geographic distribution of these beds it suggested was 300 in the lower mainland, 100 on Vancouver Island, 100 in the Thompson/Okanagan/Kootenay region, and 50 in the northern part of the province.

The ministry requested the British Columbia Mental Health Society to coordinate planning the replacement and decentralization of a downsized Riverview Hospital. The Society is using a consultant to conduct the work required for what is now described as the Riverview Hospital Replacement Project.

The consultant is an experienced project management organization and has brought well-established principles and practices of project management to the task. Planning for decentralization is still in the early stage.

The matter of staffing is a significant issue at Riverview Hospital. Employees at the hospital have public servant status even though operation of the hospital was removed from the Ministry of Health in 1988. This means they have tenure and seniority rights that extend beyond the employment relationship with the British Columbia Mental Health Society. For this reason, we believe the ministry must take the initiative to develop a way of dealing with the employees who will become surplus to the hospital's ongoing requirements.

To date, staffing reductions have been accomplished in accordance with collective agreements, taking advantage of opportunities created by staff turnover and community placement initiatives. In the 1992/93 fiscal year, the ministry and Riverview Hospital worked together to create a pilot Labour Adjustment Strategy for nurses, a project aimed at facilitating movement of hospital nurses to positions in the community. The strategy appears to be a reasonable approach to providing training, orientation, counseling, and encouragement to staff. Specific initiatives included community experience programs, competitions restricted to certain potential candidates, secondment opportunities, peer counseling, and career development programs. We believe the Labour Adjustment Strategy for nurses could be used as a template for other categories of employees at the hospital.

There are also pilot projects under way, in the 1993/94 fiscal year, to develop a strategy for shifting health care workers from the hospital to the community.

The Human Resources Working Group of the Mental Health Plan Implementation Steering Committee is developing a comprehensive labor adjustment strategy involving the entire province and Riverview Hospital. Such a strategy will have to be developed within the context of existing collective agreements.

We believe the ministry would derive substantial benefit from adopting more formal project management techniques. Application of these concepts—specifically, project plan documentation and control—would help the ministry better manage the replacement of Riverview Hospital. The essence of project management is project control, and to achieve that requires careful documentation and maintenance of a plan. The basic elements of a project are defined in its plan: what will be produced, when, and how much it will cost. If any of these elements change, either intentionally or as a result of external forces, the plan must be amended to reflect reality.

Project Management

Much of the value of a plan is not in its existence, but in the processes of developing and updating it over time. Developing a plan forces an organization to deal explicitly with what its current status is, what it wishes to become, and how it will make the transition. Updating the plan forces the organization to assess how appropriate the plan is, how effectively the plan is being executed, and what steps are

needed to address any variances from the plan.

In addition to those elements already identified as necessary in an implementation plan, two others are critical to make project management effective:

- provision for monitoring and evaluation of progress, and
- provision for approving the plan and controlling changes to it.

In our opinion, the application of these formal project management techniques would give the ministry some assurance that it is meeting the objectives of the project within established time and funding parameters. By exercising project control, the ministry would be able to review its achievements, compare them to its plans, and revise its long-term plan to reflect any variances between plans and actual progress. In this way the ministry could determine whether it would be able to deliver on the commitments made in the Mental Health Initiative and, if it could not, to identify what the ramifications of that inability might be. Because events do not always follow forecasts, we think the ministry should update its plans to reflect actual events, identify the implications of variances from plans, and make changes where appropriate.

The one- and five-year plans contained in the Strategic Mental Health Plan for British Columbia (1992) recognized that the forecasts made in 1990 were out of date. Nevertheless, aside from annual capital and operating budget documents, we found no evidence of any attempt by the ministry to update its initial draft schedule to redefine targets for each of the remaining eight years of the original timeframe for implementing the Mental Health Initiative, or to adjust the time frame to reflect the lack of funding in the second year of the project.

CHANGES IN THE MINISTRY

Since the announcement of the Mental Health Initiative in 1990, there has been an election, a change of government, the report of the Royal Commission on Health Care and Costs, development and introduction of programs in response to the report of the Royal Commission, passage of legislation that will create a new system of governance for the health care system, several changes at the ministerial and deputy-ministerial level, and many changes within the British Columbia Mental Health Society. Currently, an extensive reorganization of the ministry is taking place.

This is the environment within which planning for and implementing the Mental Health Initiative has taken place.

There are a number of signs that the ministry has now achieved an improved focus on the planning and implementation of the Mental Health Initiative. The ministry has indicated to us that it is going to put some project management practices in place to direct and control the implementation of the Initiative. We are encouraged by these steps and recommend that the ministry pursue this direction.

Recommendation: The ministry should apply the principles and practices of project management to manage the replacement of Riverview Hospital and the accompanying transfer of patients from Riverview Hospital to the community.

We believe that the ministry needs a formally documented plan to ensure there is a clear and shared understanding by all parties of the sequence, timing, and financial effect of each activity that must take place to bring about the shift from institution-based to community-based service delivery. If changes to the plan are necessary or desirable, documentation of those changes, their impact, and their approval would provide a benchmark for accountability.

Recommendation: The ministry should prepare a detailed plan for the replacement of Riverview Hospital and update it annually.

Reporting to the Legislative Assembly

The programs delivered by the Ministry of Health are among the most important of the provincial government. Mental health programs are a relatively small but significant component of those programs. They are also among those most in need of improvement. The government, in announcing the Mental Health Initiative, made a public commitment to improve mental health care programs in British Columbia. It is therefore incumbent on the government to report publicly on the status of this commitment.

We expected the ministry to provide sufficient information to the Members of the Legislative Assembly about the progress of establishing community-based care for persons with mental illness and of replacing Riverview Hospital. "Sufficient" information we defined as that which would enable the Members of the Legislative Assembly to assess the ministry's performance in meeting the commitments made in the Mental Health Initiative. We believe ministry annual reports should present meaningful, pertinent information in a format that is easy to read and assess.

We looked at what information the ministry collected on the care provided by the hospital and that available from the community, and at what it reported to the Legislative Assembly about these.

Conclusion

The Members of the Legislative Assembly have not been provided with adequate information about the planning for the transfer of patients and funding from Riverview Hospital to the community.

Findings

The ministry collects, or has access to, a wide variety of information:

- It has information on funding provided to the British Columbia Mental Health Society for operating Riverview Hospital, on bed and treatment capacities of Riverview Hospital, and on number of admissions and discharges. It has access to information that could include information about reason for admission, length of stay, basis of discharge, initial destination at time of discharge, and frequency and reasons for readmission, as well as other information from which it might assess the cost and effectiveness of providing treatment in a specialized psychiatric hospital.
- It has information that identifies funding for ministry operations in the community (including ministry contributions to publicly funded service providers), types and numbers of residential facilities and services available, utilization rates, as well as access to other information from which it might assess the cost and effectiveness

of providing care for persons with mental illness in the community.

- It has information that would permit it to report on the transfer of patients to community-based services, the downsizing of Riverview Hospital, and the financial implications of these changes.

The ministry's annual report is the primary source of accountability information available to the Legislative Assembly. The most recent annual report covers the period from April 1, 1991, to March 31, 1992, a period before which transfer of patients and funding to the community as part of the hospital replacement process had started. At the time of our audit, the ministry had not yet reported on the period from April 1, 1992, to March 31, 1993. It therefore had not yet provided information to the Legislative Assembly about the transfers of patients and funding from Riverview Hospital to the community.

Our review of the ministry's annual reports covering the period since the announcement of the Mental Health Initiative reveals there has been no reporting of progress in the implementation of the Initiative. The narrative portions of the three reports dealing with Mental Health Services are virtually identical, making no reference to bed closures at Riverview Hospital and indicating the only change in community-based services to be a decrease in the average number of community residential care beds occupied daily. Only by tracking daily bed occupancy averages for Riverview Hospital and community residential care, from year to year over the period since 1984, can one see a trend indicative of a decrease in hospital beds and an increase in community residential beds.

No information is reported on the relative costs and effectiveness of providing care for persons with mental illness in the community.

Recommendation: The ministry should provide the Members of the Legislative Assembly with sufficient information about the progress of establishing community-based care for persons with mental illness and of replacing Riverview Hospital to enable the Members to assess the ministry's performance in meeting the commitments made in the Mental Health Initiative.

Ministry Response

The Ministry of Health welcomes the Auditor General's Report on the Value-for-Money Audit of the transfer of patients from Riverview Hospital to the community, and appreciates the thoroughly professional and sensitive manner in which the audit was conducted. The Ministry accepts the findings noted in the Report and will endeavour to ensure that its recommendations are fully implemented.

The Ministry is very aware of the need to take great care in planning and implementing transfers of patients from Riverview Hospital to ensure that patients, families, staff and communities are well prepared for their new responsibilities. We are conscious of the fact that similar changes in a number of other jurisdictions have not been effectively or responsibly carried out, and are determined that this change process should be properly managed in British Columbia so that everyone benefits as a result. This Value-for-Money Audit will assist in ensuring that this important project is managed as effectively and efficiently as possible, and that public confidence in mental health reform is maintained.

The Ministry is pleased that the Report acknowledges that the transfer of patients from Riverview Hospital to community care carried out in 1992/93 was adequately planned, implemented, and evaluated. The transitional funding required for the transfer was first provided in that year, together with very substantial additional funding to increase community mental health services generally. Even more importantly, that year marked a dramatic increase in involvement by persons with mental illness, their families, advocates and caregivers in planning, implementing and operating the services they use. The extensive consultation process with these partners in which the Ministry has engaged over the past few years has been invaluable in many ways but particularly in reaffirming a broad consensus regarding the future of Riverview Hospital and the elements of an effective care system for those with serious mental illnesses. The collective experience of the mental health community over the past two years in relation to the community resource development, patient transfers, staffing adjustments, Riverview bed consolidation and funding shifts involved in this complex project has led now to the point at which more formalized project management techniques can be used with broad support. Naturally, a formal project management approach has been taken from the outset in the companion project to develop regionalized psychiatric hospital facilities to replace Riverview Hospital, which was not included in the scope of this Audit. The successful initiation of this multi-faceted project during a period of rapid political, economic, and organizational change should be attributed to the strong commitment of the many stakeholders in mental health as well as to government leadership and support.

British Columbians can justifiably take pride in the recent national and international recognition of our provincial mental health service system. This province was singled out last year by the Canadian Mental Health Association in its national report on mental health reform as having one of the most balanced mental health systems in Canada. Also in 1993, the National Institute on

Mental Health in the U.S. rated British Columbia ahead of every American state in the effectiveness of its mental health system in addressing the problems of those with serious illnesses. Notwithstanding these encouraging reviews, we are aware that numerous additional improvements must still be made to our provincial mental health care system. The successful completion of the Mental Health Initiative, including the transfer of more Riverview Hospital patients to community care, will require a continued focus on mental health by the Ministry of Health and by the developing Regional Health Boards and Community Health Councils over the next several years.

With regard to the three recommendations in the Report, the Ministry has the following comments:

Recommendation 1: Apply Project Management Principles and Practices

The Ministry supports this recommendation and has already begun to take steps to implement a more formalized project management approach in the patient transfer project, as has been the practice within the companion hospital replacement project. For example, a "Fiscal Framework" outlining the financial parameters for the remainder of the entire Mental Health Initiative is being developed collaboratively with Riverview Hospital at the present time. Care will be taken to ensure that there is an appropriate management focus within the Ministry of Health for the project management task.

Recommendation 2: Prepare an Annual Detailed Plan

The Ministry supports this recommendation and will be publishing a detailed plan later this year outlining progress on the Mental Health Initiative, including specific objectives, an implementation strategy and timetable for these to be achieved, plans for the development of community care and replacement hospital facilities, adjustments in human resources and funding, and for monitoring and evaluation.

Recommendation 3: Provide information Regarding the Status of the Mental Health Initiative to the Legislative Assembly

The Ministry supports this recommendation and will include in its Annual Report a section reporting on the status of the Mental Health Initiative, including a summary of the Annual Detailed Plan referred to in the last recommendation.

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AUDITOR GENERAL

Value-for-Money Audit

MINISTRY OF HEALTH

Psychiatrist Services

Ministry of Health

Psychiatrist Services

Contents

Ministry of Health

Psychiatrist Services

An audit of how the ministry is ensuring psychiatrist services are accessible to the seriously mentally ill

The Ministry of Health's mission is to maintain and improve the health status of all British Columbians and, in so doing, it aims to ensure that both its programs and personnel are equitably and efficiently distributed throughout the province. One important element in meeting this responsibility is to ensure that those with serious mental illness have appropriate access to psychiatrist services when needed.

Audit Purpose and Scope

We conducted our audit to assess how the Ministry of Health ensures that psychiatrist services are accessible to the seriously mentally ill in a cost-effective way. First, we looked to see whether the ministry had developed a good understanding of the state of psychiatrist accessibility in the province and whether it was actively trying to deal with any significant access problems identified. We then looked at management issues that can have an impact on the provision of psychiatrist services. Specifically, we assessed whether the ministry has:

- established what it wants to accomplish in mental health and the roles and responsibilities of those involved in providing psychiatrist services;
- established accessibility objectives and standards for psychiatrist services;
- monitored, evaluated, and reported on its performance; and
- informed the Legislative Assembly about the extent to which the ministry's accessibility objectives are being met in a cost-effective manner.

We focused our review on the period from September to November 1993, also looking at initiatives being planned at that time. Our examination was performed in accordance with value-for-money auditing standards recommended by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures we considered necessary in the circumstances.

Overall Conclusion

The ministry is aware that British Columbia has significant psychiatrist accessibility problems for the seriously mentally ill. These difficulties stem from a geographic maldistribution of psychiatrists and an inadequate supply of their services in many public sector facilities. This is not unique to British Columbia: other jurisdictions in Canada face similar problems. The ministry has developed strategies to help address the problems but, so far, they have met with limited success. Resolution of these issues will require the cooperation and support of the British Columbia Medical Association. Recently, the ministry and the British Columbia Medical Association established a joint committee to look at issues related to psychiatrist supply, deployment, and remuneration. We believe this is a positive step.

In addition to trying to improve psychiatrist accessibility, the ministry also needs to ensure that it is managing well in those areas that can affect the provision of psychiatrist services. We found several areas where improvements can be made.

The Mental Health Services Division has overall responsibility for mental health but it lacks the authority needed to ensure that all parts of the ministry providing related services work towards achieving the ministry's mental health goals. A recent ministry reorganization may provide better opportunities to establish appropriate authorities and coordinate services for the benefit of the seriously mentally ill.

To help guide and prioritize access to psychiatrists in both public sector facilities and private practices, the ministry also needs to clarify its mental health service priorities and clearly define its objectives and standards of service. It has begun to develop long-term objectives for the mental health care services needed around the province, including psychiatrist services, but further work is required.

The ministry does not have an adequate system to collect complete and reliable information about the state of the province's entire mental health system. This makes it difficult for the ministry to assess whether scarce mental health resources, including psychiatrist services, are being applied to the highest priority cases and whether those resources are provided cost-effectively.

Finally, the ministry does not regularly provide adequate information to the Legislative Assembly and the public about the extent to which it has been able to meet its objectives for psychiatrist services.

Key Findings

The Seriously Mentally Ill Have Significant Problems Accessing Psychiatrists

The World Health Organization recommends that communities have at least 1 psychiatrist per 10,000 population. Based on this standard, British Columbia has enough psychiatrists overall. However, significant problems exist with their geographic distribution in the province and many public sector providers, which assume the greatest responsibilities for treating the seriously mentally ill, have an inadequate supply of psychiatrist services. Other jurisdictions in Canada face similar problems.

The Ministry Has Had Limited Success at Improving Accessibility

The ministry has studied the accessibility issue and has developed some strategies for trying to improve access. Some of the primary methods involve: finding ways to introduce new funds or free up existing funds so that psychiatrists can be provided where they are most needed; training general practitioners to provide even more psychiatric services than they currently provide; periodically sending psychiatrists from relatively overserviced areas into underserviced areas to assist and train local service providers; and working with the profession to bring about the desired changes. So far, the ministry has achieved only limited success.

Resolution of psychiatrist accessibility problems will require the cooperation and support of the medical profession. Two recent events may help in this regard. First, in conjunction with the signing of the October 1993 agreement between the Province and the British Columbia Medical Association the two parties agreed to cooperate through joint committees to deal with significant health care concerns. Second, and independent from the agreement, a joint committee has been struck between the two parties to begin looking at the issues of psychiatrist supply, deployment, and remuneration. We believe these are positive steps that could lead to improvements in psychiatrist accessibility for the seriously mentally ill.

Service Priorities Need to Be Clarified

The Mental Health Services Division has been established to provide leadership in the area of mental health care services and its mission statement reflects this responsibility. The range of services sought by consumers is wide, but guidance to help providers prioritize their services amongst all competing demands is limited. More specific guidance is required if the ministry is to ensure that those most in need receive a consistent level of services across the province.

A Strong Voice for Mental Health Is Needed

Psychiatrist services are provided through a complex system involving the ministry, hospitals, societies funded by the ministry, and psychiatrists in private practice. Within the Ministry of Health, three separate divisions—including Mental Health Services, Acute Care and the Medical Services Plan—have primary responsibilities relating to mental health services. Each has its own mission and budget. Until recently, the Mental Health Services and Acute Care divisions reported to different assistant deputy ministers. The Medical Services Plan operates under the guidance of the tripartite Medical Services Commission which is composed of nine members appointed from the British Columbia Medical Association, government, and the public.

Mental Health Services has been established to guide delivery of all mental health services in British Columbia. However, many of those services are provided by hospitals and psychiatrist fees are paid by the Medical Services Plan. Mental Health Services lacks authority over these budgets. It also lacks the authority to establish reporting requirements and service delivery standards to achieve its responsibility of coordinating services provided or funded through other parts of the ministry.

A reorganization on September 29, 1993, brought Acute Care and Mental Health Services under one branch called Regional Services reporting to a single assistant deputy minister. While there are still two organizational units, the fact that they are both the responsibility of one individual may hold greater opportunities to provide a more efficient, effective and integrated system in British Columbia.

Service Objectives and Standards Are Needed

Historically, psychiatrist services have evolved in each area of the province according to factors such as historical service utilization levels, prior year budgets, and psychiatrists' choice of location. To manage the provision of services according to need and the ability to pay, the ministry first requires a good understanding of the nature and extent of mental illness in the province. It must then establish its long-term accessibility objectives and define them in terms of service standards that can be used on a daily basis by providers.

Some progress has been made in analyzing the mental health needs of the population, but further work is needed. The ministry also needs to clearly define service standards so that access to psychiatrists in the province can be better guided and prioritized.

An Information System Is Needed

Each area of the ministry having a role in the provision of mental health services collects the information it needs for its own purposes. Overall, however, the ministry does not have a system to collect relevant information about the state of the entire mental health system including all of the hospital psychiatric unit programs, community mental health centers, and private practice psychiatrists in the province. As a result, it does not have complete and reliable information about the extent of mental illness and the availability of psychiatrist services in each region of the province. It also lacks information to assess whether scarce psychiatrist resources are being applied to the highest priority cases and whether they are provided cost-effectively. Improving the information system is identified as an important element in the ministry's mental health strategic plan. Consumer confidentiality is a major issue that the ministry will need to overcome to be in a position to gather the information it needs to manage the mental health system effectively.

The Ministry Is Not Able to Report on Its Performance

Because the ministry lacks defined accessibility objectives and complete information about mental health services around the province, performance information is not well developed. As a result, the ministry is unable to report meaningfully to the Legislative Assembly about its performance in providing mental health services. It has gathered information about psychiatrist accessibility issues and its efforts to deal with these matters, but it has not included this information in its public reporting.

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The Ministry's Role in Providing Psychiatrist Services

Mental Illness

Knowledgeable observers agree that 3-5% of all people, at any one time, are afflicted with a serious mental illness such as schizophrenia, bi-polar disorder (for example, manic-depression), or a paranoid disorder that requires intervention by professionals in the mental health care system. It has been further estimated that up to 20% of people, at any one time, are affected by personal, family, or situational difficulties which cause them to seek assistance in the mental health system.

Mission of the Ministry of Health

The Ministry of Health's mission is to maintain and improve the health status of all British Columbians. In doing so, it aims to ensure that both its programs and personnel are equitably and efficiently distributed throughout the province. The ministry has recognized, as important elements needed to accomplish its mission, the provision of assessment, prevention, and treatment services related to mental health and the identification of priorities to strengthen community mental health resources across the province.

Providing Mental Health Care Services

The Mental Health Services Division was created by the ministry to guide the provision of mental health services. According to the division's 1993 Strategic Plan, the overall mission of Mental Health Services is "to restore, preserve and promote mental health for people of all age groups by ensuring provision of effective and responsive services." The division carries out its mission through:

- direct service delivery;
- the purchase of treatment support and rehabilitative services; and
- the overall coordination of services delivered by other divisions, ministries, and private agencies (Exhibit 2.1).

Services are delivered to a diverse range of demographic groups (adult, senior, and child and youth) through a variety of community outpatient and inpatient settings.

Direct Service Delivery

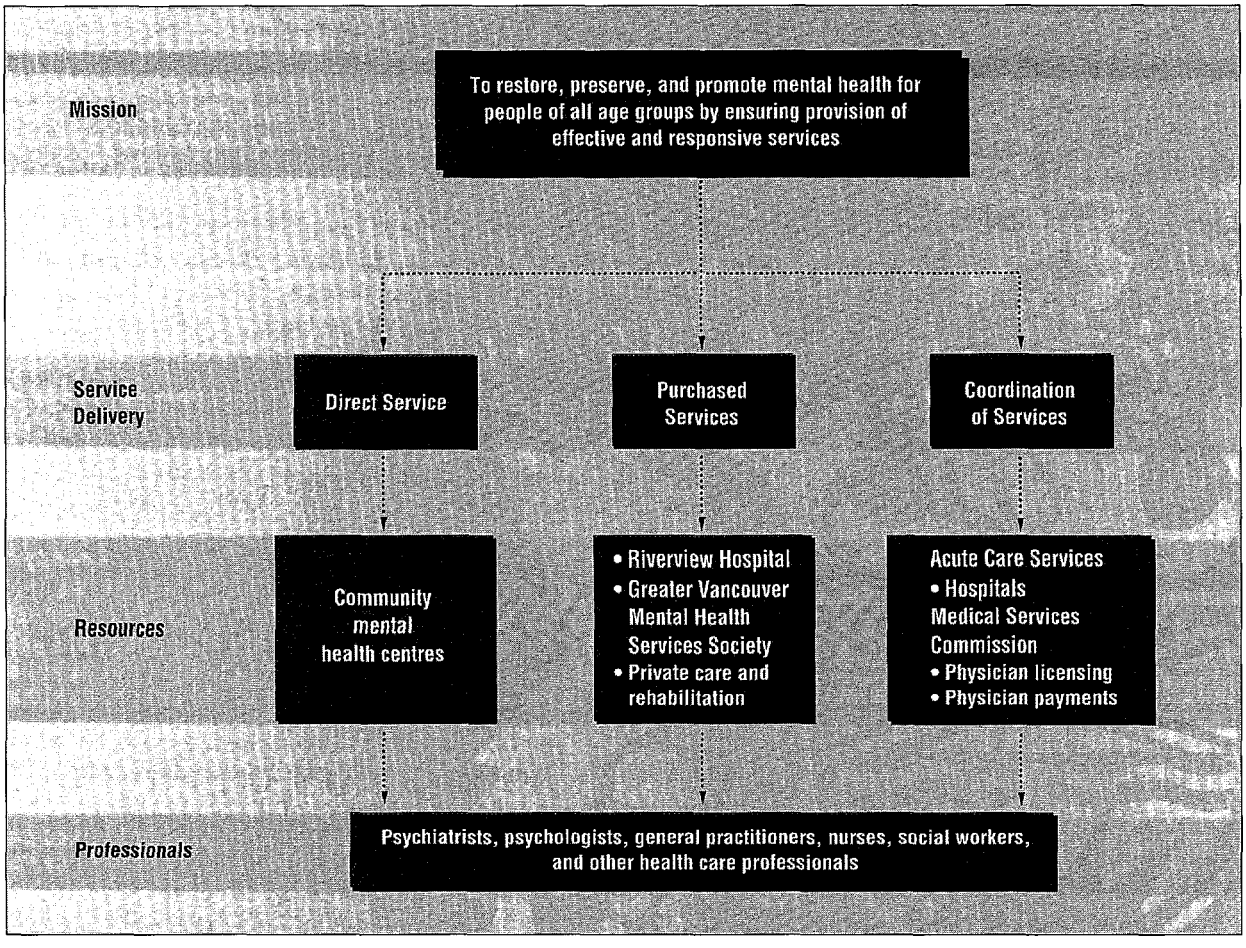
Direct service delivery is handled by Mental Health Services Division staff. Programs are directed centrally and managed regionally through 96 centers and sub-offices located in the ministry's five regions (Fraser Valley/North Shore, Vancouver Island, the North, Thompson/Okanagan/Kootenays (TOKO), and Burnaby). Burnaby is unique from the other regions in that it operates a 25-bed, short-term inpatient unit which is integrated with services provided by community outpatient teams.

At all of these community health care centers, consumers with mental illness who do not require hospitalization are provided

Exhibit 2.1

Service Delivery Chart

A chart showing the various means used by the Mental Health Services Division to achieve its mission



Source: Annual Report of the B.C. Ministry of Health

with assessment, stabilization, long-term treatment, rehabilitation, case management, and monitoring services. Center staff also coordinate local services and programs focused on maintaining optimum mental health in the community.

During the 1992/93 fiscal year, Mental Health Services spent approximately $41 million providing direct mental health services (Exhibit 2.2).

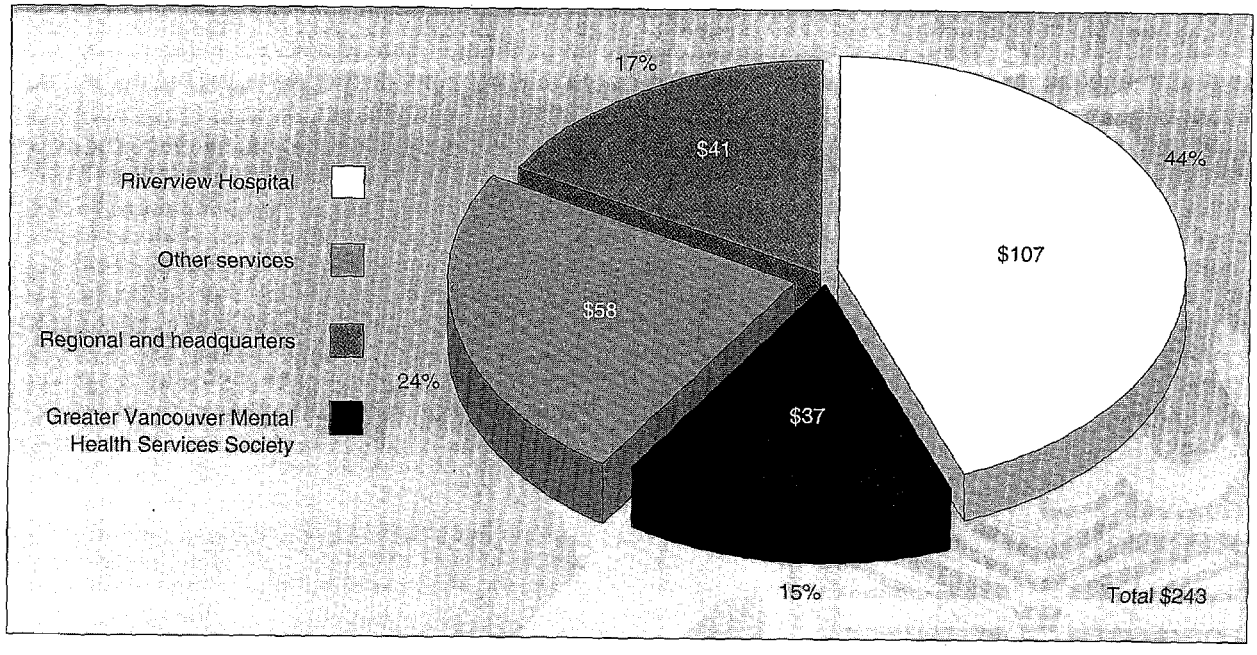
Purchased Services

Comprehensive services in Vancouver and Richmond are purchased by Mental Health Services from the Greater Vancouver Mental Health Service Society. The Society consists of 9 multidisciplinary teams, each with approximately 25 members and its own catchment area. The Society views the treatment of serious mental illnesses as its mandate. It has an active caseload of 4,200

Exhibit 2.2

Mental Health Services Division Expenditures

For the year ended March 31, 1993 ($ Millions)



Source: B.C. Ministry of Health

adults and children and evaluates 7,000 new referrals each year. During the 1992/93 fiscal year, Mental Health Services granted $37 million to the Society to support its operations (Exhibit 2.2).

The Mental Health Services Division also purchases services from the British Columbia Mental Health Society which operates Riverview Hospital. Riverview provides medium- to long-term care for about 900 individuals with serious mental illness. Under the auspices of the Mental Health Initiative announced in 1990, this institution will be replaced over the next decade with a range of smaller regional psychiatric inpatient facilities. In addition, the number of patients at Riverview will be reduced through patient transfers to community-based programs. During the 1992/93 fiscal year, Mental Health Services gave grants totaling $107 million to Riverview to support its operations (Exhibit 2.2). We conducted a separate audit on the downsizing of Riverview Hospital. The results of that audit are presented in the section of this report entitled "The Transfer of Patients from Riverview Hospital to the Community".

Other purchased services include those for community residential care and rehabilitation services. Residential care services provide living arrangements, ranging from semi-independent, apartment-style residences to

specialized long-term care programs. Rehabilitation programs range from pre-vocational training to instruction in basic life and social skill development. During the 1992/93 fiscal year, Mental Health Services spent approximately $58 million to purchase community residential care and rehabilitative services (Exhibit 2.2).

Coordination of Services

The Mental Health Services Division is expected to coordinate the ministry's inter-departmental interests. Besides the division, the two other major ministry groups involved with providing mental health services are Acute Care and the Medical Services Plan.

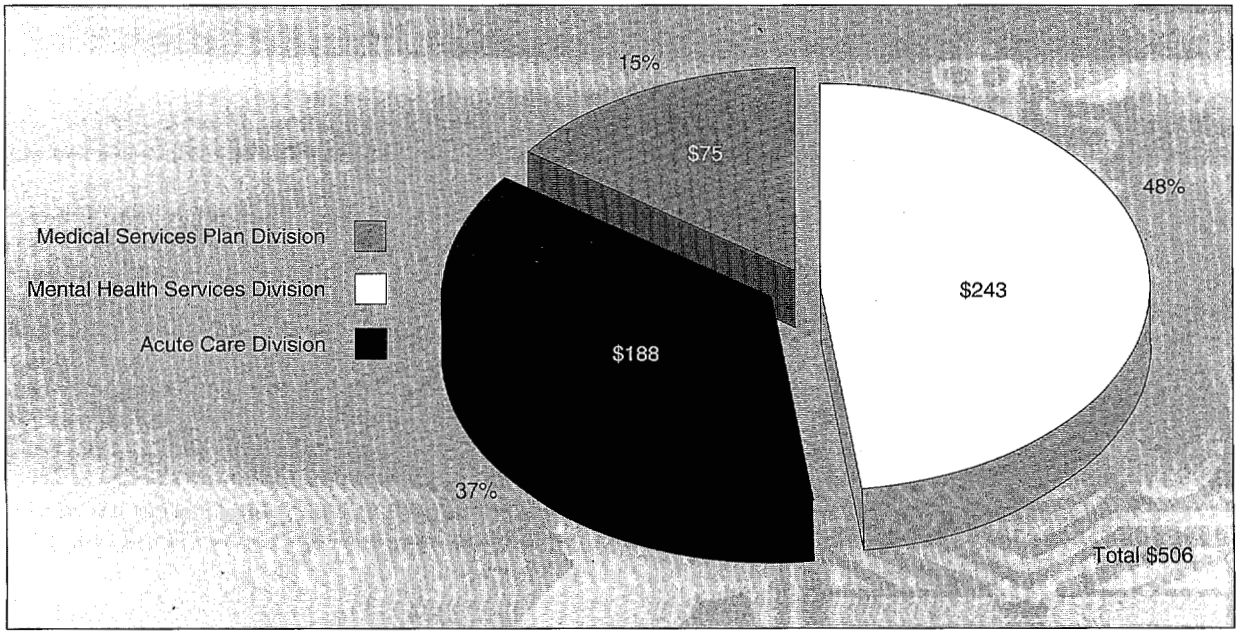
Although the Minister of Health is ultimately responsible for all services delivered, hospitals are operated by autonomous societies. Acute Care is primarily a funding agency and leaves operations to the institutions. It does, however, undertake some monitoring of the quality of care in hospitals throughout British Columbia.

According to the ministry, there are 123 hospitals across British Columbia, 31 with psychiatric wards. At any given time, about 714 acute psychiatric inpatient beds are available in these hospitals. During the 1992/93 fiscal year, Acute Care provided approximately $188 million to hospitals to provide mental health services (Exhibit 2.3).

Exhibit 2.3

Ministry of Health Expenditures on Mental Health

For the year ended March 31, 1993 ($ Millions)



Source: B.C. Ministry of Health

The Medical Services Plan group has the main task of administering the province's medical insurance plan by registering subscribers, billing premiums, and paying for services rendered to individuals covered by the plan. It also monitors practitioners and their patterns of practice, investigates misuses of the plan, and participates in fee negotiations with the British Columbia Medical Association (BCMA) for services rendered under the plan. During the 1992/93 fiscal year, the Medical Services Plan spent approximately $75 million for psychiatrist services provided throughout British Columbia (Exhibit 2.3). Together, these three areas of the Ministry of Health spent $506 million during the 1992/93 fiscal year.

Providing Psychiatrist Services

The provision of mental health care services is a large and complex task involving large annual expenditures of public funds and a wide range of professionals, including psychiatrists, psychologists, general practitioners, psychiatric nurses, social workers, and other health care professionals.

While some of these professionals have either specialized training in the assessment and treatment of the mentally ill or the authority to prescribe medications, psychiatrists are distinguished in this group by having both. Consumer access to appropriate psychiatrist services can lead to early diagnosis and treatment, resulting in a better quality of life for consumers and, potentially, reduced overall costs for the health care system.

All psychiatrists in British Columbia are paid with public funds. There are, however, two systems of providing the service: public sector psychiatry and private practice psychiatry.

Public Sector Psychiatry

Public sector psychiatry refers to those psychiatrist services provided in general hospitals, Riverview Hospital, and community mental health centers. Psychiatrists working in these organizations generally work as part of a multidisciplinary team made up of a group of health care professionals.

Consumers served by the public system generally include those who are:

- severely mentally ill and require the services of a tertiary care psychiatric hospital;
- acutely mentally ill and require occasional hospital emergency department care and possibly admission to the inpatient psychiatric unit to deal with their crisis;
- chronically mentally ill and experience severe and persistent mental health concerns which can be treated by mental health centers and hospital emergency departments on an outpatient basis; or
- not mentally ill but affected by personal, family, or situational difficulties which cause them to seek assistance in the public mental health system.

In general, psychiatrists who provide services in the public sector as part of a multidisciplinary team are paid by the Medical Services Plan, according to the "sessional" fee schedule negotiated with the BCMA. Each session covers a 3.5-hour time period. Public sector mental health care providers must have Medical Services Commission approval before hiring psychiatrists on a sessional basis. If, for example, a hospital has obtained approved funding for sessions and psychiatrists willing to work them, it will enter into contracts with those psychiatrists to provide their services in the hospital. The contract specifies the nature of the services to be provided during the session, the hours of the day during which services are to be provided, and the frequency (for example, one session per week). During the 1992/93 fiscal year, the ministry spent $20 million on sessional psychiatry in public sector facilities (Exhibit 2.4).

A full-time sessional psychiatrist could work 10 sessions (35 hours) per week, but few actually work full-time in the public sector. The majority have private practices and some make part of their time available for work in the public sector on a sessional basis.

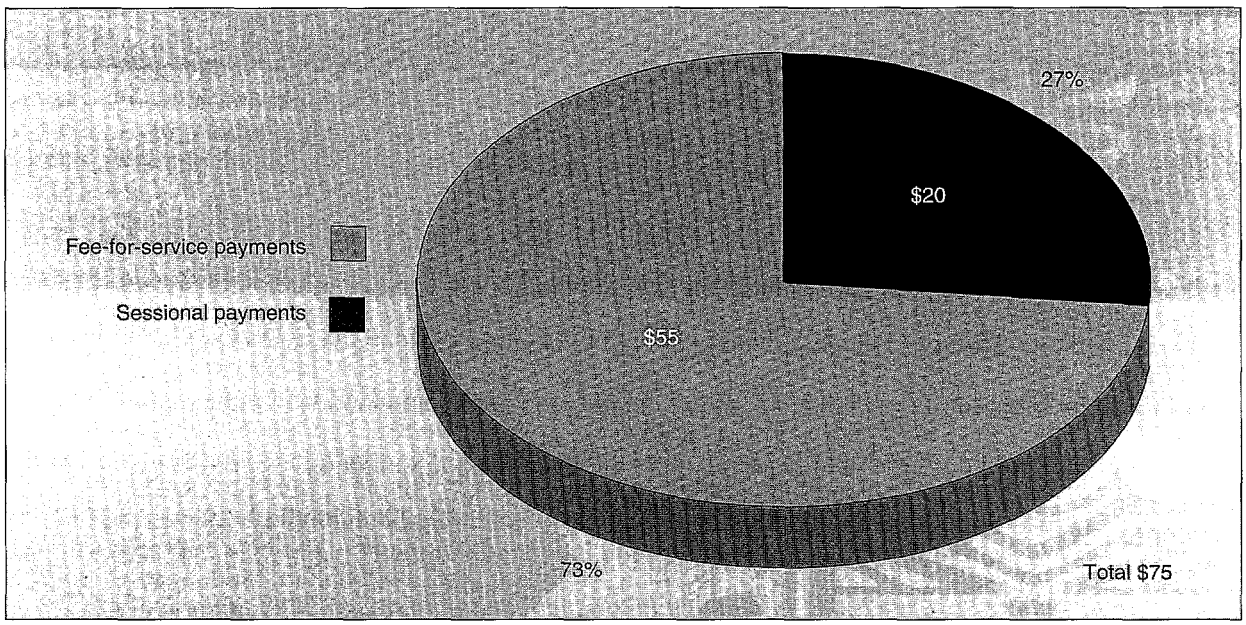
Private Practice Psychiatry

Like other medical practitioners, many psychiatrists establish private practices. Consumers served are generally those who come for assessment and treatment as a result of referrals

Exhibit 2.4

Payments to Psychiatrists

For the year ended March 31, 1993 ($ Millions)



Source: B.C. Ministry of Health

from general practitioners. In general, consumers using services of private practice psychiatrists tend to have less severe and less debilitating mental illnesses than do those treated in the public sector. Most of the services they provide are office based and require little of the support services found in the public sector. However, if their clients become hospitalized and the psychiatrists have admitting privileges, services can be provided in hospital.

Private practice psychiatrists are also paid for their services by the Medical Services Plan. However, they are paid according to the "fee-for-service" schedule negotiated with the BCMA. The fee schedule prescribes specific services covered by the medical plan and the amount paid for each service. During the 1992/93 fiscal year, the Medical Services Plan spent $55 million on mental health care related fee-for-service, the majority of which was paid to private practice psychiatrists (Exhibit 2.4).

Our audit examined how the Ministry of Health ensures that psychiatrist services are accessible to the seriously mentally ill in British Columbia in a cost-effective way. The following sections of the report deal with our findings.

Accessibility to Psychiatrist Services

A key element of the ministry's mission is to ensure that its programs and personnel are equitably and efficiently accessible throughout British Columbia. This also applies to psychiatrist services, a key element in the delivery of mental health services. We expected the ministry to know the degree to which psychiatrist services are accessible for the seriously mentally ill throughout the province and to be actively pursuing improvements where warranted.

Conclusion

The ministry is aware that British Columbia has significant psychiatrist accessibility problems for the seriously mentally ill which stem from a geographic maldistribution of psychiatrists and an inadequate supply of their services in many public sector facilities. This is not unique to British Columbia: other jurisdictions in Canada face similar problems. Those in the ministry involved with providing psychiatrist services have identified many reasons for these accessibility problems and have proposed solutions to help improve access. However, to date, they have met with limited success and accessibility problems persist. Resolution of these issues will require the cooperation and support of both the ministry and the BCMA. In this regard, a joint ministry/BCMA committee has recently been struck to look at the issues of psychiatrist supply, deployment, and remuneration. We believe this represents a positive step towards improving accessibility to psychiatrists by the seriously mentally ill.

Findings

Psychiatrist Accessibility Issues

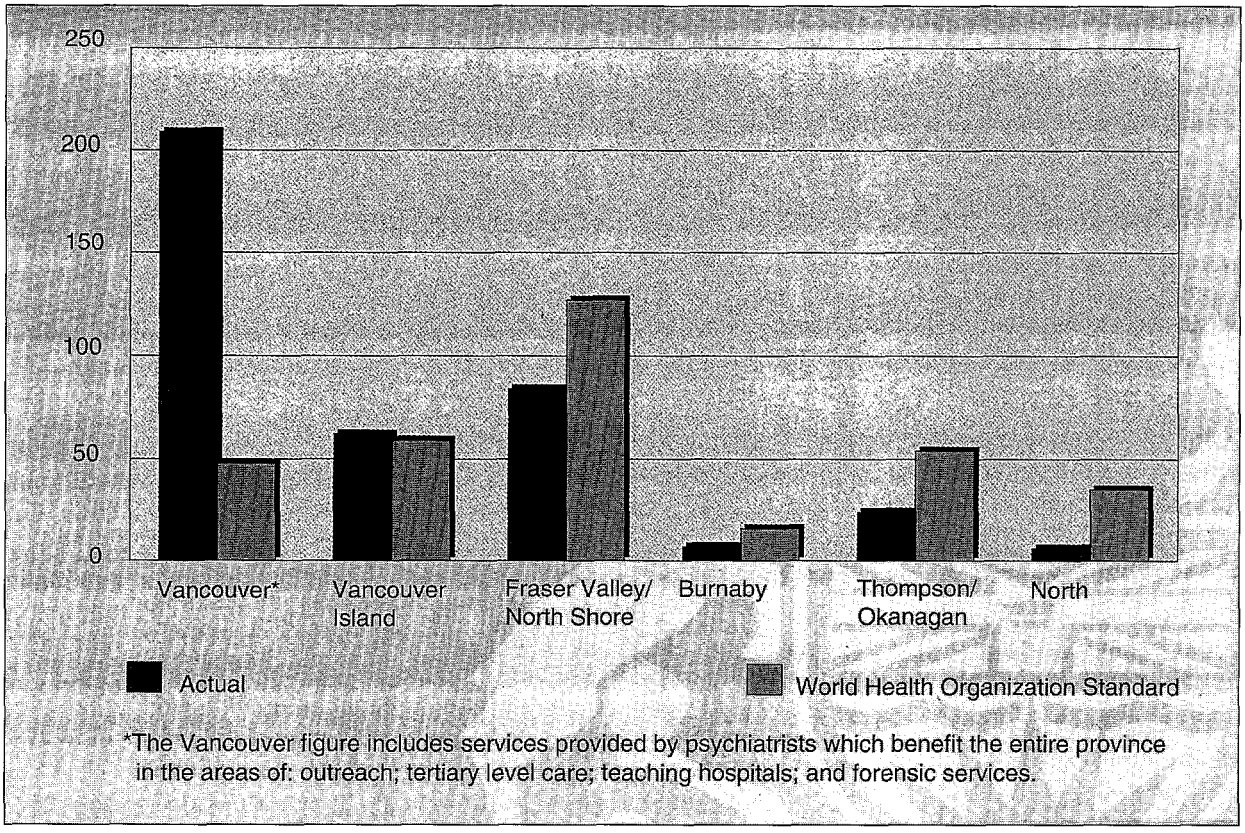
The World Health Organization suggests that communities should have at least 1 psychiatrist per 10,000 population. According to the ministry, there are 392 psychiatrists in British Columbia, an average of 1 per 8,700 population.

While these figures suggest that there is an adequate number of psychiatrists for the province overall, further analysis shows that they are disproportionately distributed around the province (Exhibit 2.5). As a result, some areas are overserved, based on this ratio, while other areas are greatly underserved. For example, according to the ministry, 209 of the province's 392 psychiatrists are located in Vancouver. The ministry data also show that 65 of the 392 psychiatrists are over the age of 65 and are either retired or work part-time. If one assumed that all of those 65 lived in Vancouver and were effectively removed from full-time service, that would still leave 144 psychiatrists in the area. The World Health Organization ratio suggests that there should only be 48. The Northern region, on the other hand, has only 6 psychiatrists; the World Health Organization ratio calls for 35 there (Exhibit 2.5).

Exhibit 2.5

Regional Distribution of Psychiatrists in British Columbia

As at December 31, 1993



Source: B.C. Ministry of Health

A level of services higher than that suggested by the World Health Organization for the Vancouver region might be justified to some degree. Riverview Hospital has, over the years, been responsible for tertiary care for the province, and so those with serious mental illness are frequently cared for in the lower mainland. Research also suggests that mentally ill people prefer the anonymity of large urban centers. Given these factors, Vancouver can be expected to have a larger population of mentally ill people per capita than, say, the North. Also, the high level of services in the Vancouver region can be partially explained because the lower mainland is the centre for training, outreach and forensic services. As a result, there is some justification for a level of services in excess of the norm, but, as most providers would agree, not enough justification for the high imbalance across the province.

In some of the highly underserved areas, a consumer may have little chance of seeing a psychiatrist. That consumer is more likely to be treated by a

general practitioner who may or may not have some additional psychiatry training beyond that needed to qualify as a general practitioner.

In addition to geographic maldistribution of psychiatrist services, many hospitals and community mental health centers indicate they have an inadequate supply of psychiatrist services. Their experience is that, while a need for additional psychiatrist services has been identified in their facilities, often these needs go unmet. For example, even in the lower mainland, some hospitals and community mental health centers have difficulty recruiting and retaining psychiatrists.

Historical Perspective

To understand psychiatrist accessibility problems as they exist today, it is important to understand some historical issues. The government has traditionally been responsible for community mental health services and long term-care of the most seriously mentally ill. Over the years, this care has been provided through Riverview Hospital by physicians employed on a salary.

With the advent of the *Canada Health Act*, all physician services came to be governed by agreements between the province and the BCMA. Under this arrangement the government allocates money to the BCMA which, in turn, allocates the money to be spent on specialist services such as psychiatry. The funds allocated for psychiatry were used primarily for private office-based fee-for-service psychiatry, while services provided for the seriously ill at Riverview Hospital continued to be paid directly by the province.

With the evolution of psychiatric care, many patients who in past would have been kept and treated in Riverview could now be treated in the community. The patient population of Riverview went from about 4,300 in 1956 to about 900 today. Once patients were discharged, though, there was often no psychiatrist to accept responsibility for care. This led to the growth of the community mental health system as a way of following and caring for these people. For a variety of reasons, however, the public sector providers have had limited access to psychiatrist services.

Causes of Psychiatrist Accessibility Problems

Many factors contribute to the problems of recruiting and retaining psychiatrists in the public sector and in underserved areas. These factors can be broadly categorized under:

- remuneration
- nature of the work
- geographic location.

Remuneration One of the primary remuneration disincentives cited by knowledgeable observers is that psychiatrists working in the public sector on a sessional basis are believed to earn 25-30% less than those working in private practice on a fee-for-service basis. One reason for this is that when psychiatrists work on a sessional basis they are paid a flat rate for each 3.5-hour session. When

psychiatrists work on a fee-for-service basis they are paid a set fee for each service they perform, in accordance with the Medical Services Plan fee schedule. The more services they perform the more they earn.

Another disincentive for psychiatrists thinking of offering services to the public sector has to do with the sessional rate structure. The highest sessional rate for a psychiatrist is currently $322 per session; the lowest is $270 per session. The rate paid depends on the psychiatrist's fee-for-service billings. If total billings are high, then the highest sessional rate is paid; if total billings are low, then the lowest rate is paid. This differential is intended to provide a comparatively higher sessional rate to compensate those psychiatrists who are foregoing high fee-for-service earnings. However, as they spend more time providing sessional services, their fee-for-service billings can decline, with the result that they no longer qualify for the higher sessional rate.

A final remuneration-related reason that some psychiatrists do not work in the public sector is that often the hospital or mental health center in their area simply does not have the sessional funds available to pay for their services. This sends a mixed message to those private practice psychiatrists who, on one hand, are being asked to provide more services in the public sector but are turned down because the public sector providers in their community lack the sessional funding needed to obtain their services.

As a result of these issues, psychiatrists providing services in the public sector feel they are not adequately compensated compared with their private practice colleagues who work only on a fee-for-service basis and face more limited demands for emergency services after normal business hours ("on-call"). In one area, these concerns eventually led to psychiatrists completely withdrawing their services for psychiatric emergencies at the hospital. At the time we were writing this report, on-call access to psychiatrists in this area remains a problem.

Nature of the Work Providers also indicate that the nature of the consumers treated under the two systems can act as a disincentive to psychiatrists providing services in the public sector. Most agree that consumers treated in the public sector tend to be the most seriously ill and the most difficult to treat. In contrast, it is generally acknowledged that consumers treated by private practice psychiatrists tend to be less seriously ill and hence more professionally satisfying to treat.

There are several reasons for this difference. One is that seriously ill consumers can be difficult to deal with and disruptive to a private practice model of service delivery. Given the high demand for services as well as the broad range of services that qualify under the Medical Services Plan, private psychiatrists can be more selective about who they treat. Furthermore, it is commonly acknowledged that the most seriously ill are best treated by a multidisciplinary team of

professionals. This multidiscipline treatment model is not compatible with the private practice model because the fee-for-service schedule does not allow billings that would be needed to cover psychiatrist consultations with other professionals.

Another work-related issue cited as contributing to the difficulty in recruiting and retaining psychiatrists in the public sector is that they face greater pressures to provide on-call services than do their counterparts in private practice. Some private practice psychiatrists have chosen not to have hospital privileges because their clients are generally not seriously ill and therefore require fewer hospital services. As a result, these psychiatrists face limited on-call requirements. In contrast, psychiatrists working either full-time or part-time in the public sector major hospitals are frequently required to provide on-call services. Those working on-call in hospitals may find themselves in the professional and legal position of having to take responsibility for consumers they admit to hospital and those they discharge, even though their private practice is full. Under the fee-for-service model, in cases where the consumer lacks coverage under the Medical Services Plan, the psychiatrist may have difficulties getting paid.

Finally, some observers say that many psychiatrists have qualified and practiced during a time when fee-for-service has been the primary method for physician remuneration. More recently, public sector psychiatry, paid on a sessional basis, has been evolving and requires psychiatrists to work in a multidisciplinary team environment where they are organizationally responsible to someone else who may not be a physician. For many psychiatrists, this may make public sector psychiatry an unattractive alternative.

Geographic Location Many geographic location issues also affect the recruitment and retention of psychiatrists to underserved regions of the province. For one, the most underserved areas tend to be outlying parts of the province. Psychiatrists, like other professionals who have the option, may simply prefer the lifestyle offered by the larger urban centers. Psychiatrist training has tended to place emphasis on the practice of psychiatry in large urban areas rather than on practicing in rural and outlying areas. Many psychiatrists prefer a close proximity to the "teaching hospitals," all located in the lower mainland. Some observers also suggest that many psychiatrists come from large urban centers and have not been exposed to living in rural and outlying areas. As a result, they don't naturally choose to locate there. Although the ministry provides an isolation bonus to locate in underserved areas, it does not seem to be effective in attracting and retaining psychiatrists in these areas.

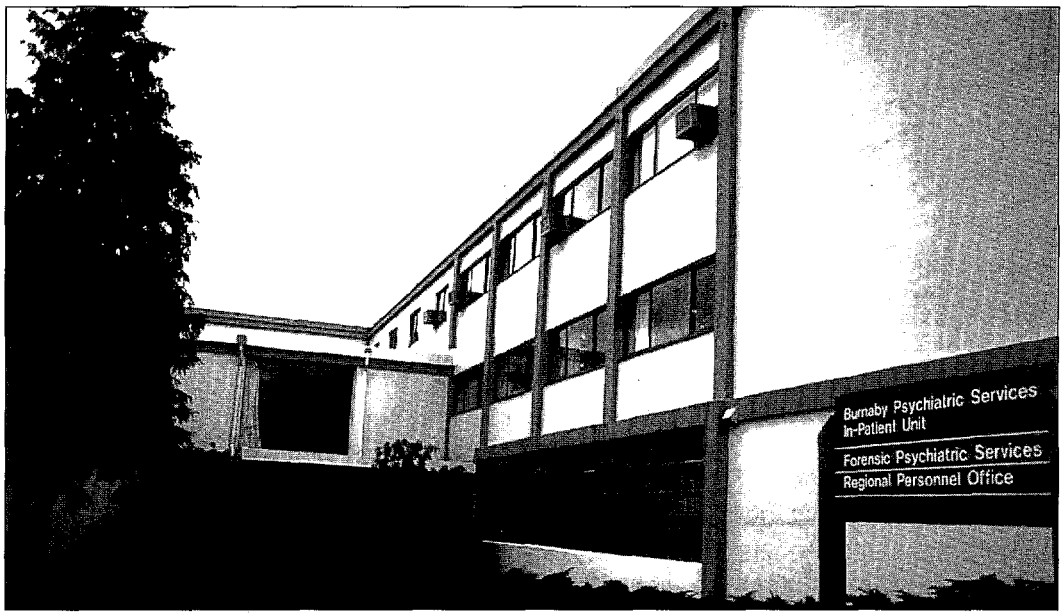
Another issue is what many providers call the need for a "critical mass" of psychiatrists in a specific area. Psychiatrists indicate that it is important to their practice and professional development to have the opportunity to interact with other psychiatrists, to have

another psychiatrist available to provide backup and alternate coverage during leaves, and to share the personal demands of after-hour services. Some providers believe that a minimum of three psychiatrists in an area is required.

A final location-related reason for why underserved areas have trouble attracting psychiatrists is that the ministry has not established a comprehensive action plan for attracting and retaining psychiatrists to these areas. For example, the ministry has not instituted either regional or provincial recruitment plans to help alleviate underservicing. Providers in underserved areas also point out that they lack recruitment budgets to help them attract psychiatrists. They also have no assurance, in most cases, that even if they are able to attract a psychiatrist to their area, adequate sessional funds will be available for the psychiatrist to work in the local hospital or mental health center. The result of all this is that the frustration level is high amongst providers in underserved areas, and accessibility problems persist.

Ministry Attempts to Improve Accessibility

In recent years, the ministry has studied the causes of psychiatrist accessibility problems and has posed some possible solutions. In 1987, for example, it prepared an internal report entitled, "Review of Psychiatrist Manpower in British Columbia." Its intent was to document and evaluate funding alternatives (including salary, sessions, and fee-for-service) and to identify where any shortfalls or surpluses of psychiatrists exist. The report concluded that "there exists a sufficient number of psychiatrists practicing in the Province. Due to the attractiveness and high earnings potential of locating in Vancouver and the lack of desire to work in remote areas and/or public



Courtesy of Ministry of Health

Burnaby Psychiatric In-Patient Unit

facilities outside of private practice, an imbalance in psychiatrist services has occurred."

Fourteen recommendations were made, aimed at improving administration of the mental health program, reducing the overall cost of providing psychiatric services, and improving the distribution of psychiatrists within the province. Some recommendations involved fundamental changes to the status quo and have not been implemented.

In the early part of 1993, the ministry struck a Provincial Psychiatry Subcommittee made up of representatives from the ministry, academia, and providers. Its mission is to "improve delivery of psychiatric care in the public sector in British Columbia through the development of strategies to provide fair and equitable compensation for physicians." Its goal is "to develop a provincial action plan that will specifically address the following issues:

- the geographic maldistribution of physicians providing psychiatric services in the province;
- the best methods of remuneration for physicians providing psychiatric services in hospitals, mental health centers and community programs; and,
- the best methods for recruiting and retaining physicians to provide psychiatric services in underserved communities, facilities and agencies."

In August 1993, the committee was presented with a ministry report on psychiatrist manpower in the province entitled, "Improvement in the Delivery of Psychiatric Medical Care in British Columbia." It summarized psychiatrist accessibility problems and outlined some potential strategies to improve access. At this time, the ministry has not yet taken an official position on the report, but both the ministry and the BCMA have agreed that it provides a useful starting point for the recently established joint committee on psychiatry.

Given that the problems of psychiatrist accessibility continue, mental health centers, hospitals, and other public sector providers have been attempting to devise their own individual solutions to try to attract and retain psychiatrists. For example:

- The Forensic Services Commission has introduced a premium of 10% over the established sessional rate for its psychiatrists.
- Some hospitals provide psychiatrists with office facilities and secretarial services so they can carry on private practice work in addition to their other duties.
- Some hospitals offer loan incentives to their psychiatrists.
- Some underserved areas hire foreign-trained graduates who, initially, do not meet the licensing requirements in British Columbia.
- Most underserved areas use the University of British Columbia Outreach Program as much as their budget allows.
- Some providers employ a service model that makes extensive use

of general practitioners and other non-psychiatrist providers.

- Fee-for-service practice, in addition to existing sessional agreements, are now being allowed by some community mental health centers.

While these measures have helped some providers attract and retain psychiatrists, the primary concerns of accessibility persist. Most providers are aware of the different arrangements that have been worked out and believe that, rather than having numerous ad hoc arrangements that put some organizations and regions at a disadvantage, they need a more coherent approach that will attract more psychiatrists to underserved areas and to the public mental health system.

Funding

In general, the solutions put forth by the ministry to improve accessibility involve finding the funds needed to recruit and retain psychiatrists to work in outlying areas of the province and in the public sector. Accordingly, the ministry has recognized that it must either find new funds to pay for these services or redirect the funds currently being spent on psychiatry in British Columbia. Given current financial times and the demands from all parts of the health care system, the ministry has determined that it cannot provide enough new funds to completely resolve accessibility problems.

The second alternative of redirecting funds currently spent on psychiatry is also a challenging task. Historically, fee-for-service has been the predominant method for funding medical care in British Columbia and throughout Canada. Physicians express the view that the issues of independence and autonomy of the physician—and of the physician-patient relationship—are paramount. They believe that their view is best supported by the fee-for-service payment approach. The government's role is to balance the physician view with its own responsibilities for providing services to achieve broader social goals: improving the health of the population; providing priority services to those most in need; and recognizing that there is a limit on its ability to pay for services. Government tends to see alternative payment approaches as giving it the flexibility needed to achieve its goals. As a result, parts of the health care system have become dissatisfied with the fee-for-service approach because of the problems it poses for the planning, coordination, and program development needs of the health care system.

These longstanding views come into play with any proposal made by the ministry to redirect the use of psychiatrist funding. Redirecting requires making changes in service delivery aimed at ensuring that the highest priority is given to providing services to the seriously mentally ill and shifting services from relatively overserved areas of the province. The ministry believes that it can best achieve these goals by balancing and redistributing the funding of psychiatry between alternative forms of payment and fee-for-service to more clearly

address local accessibility needs and service delivery models. The ministry, however, cannot make such changes unilaterally. The current agreement between the BCMA and the Province of British Columbia requires that any shifting of funds from fee-for-service to alternative forms of payment requires the prior approval of the BCMA.

Two events have recently occurred which may help the ministry improve psychiatrist accessibility. In conjunction with the signing of the October 1993 agreement between the BCMA and the Province of British Columbia, the two parties agreed to cooperate through joint committees to deal with significant health care concerns (for example, the Supply Committee which was involved with implementing the current interim restrictions on new physicians entering the province). Unrelated to the agreement, a joint committee on psychiatry has also been struck to look at the issues of psychiatrist supply, deployment, and remuneration.

Many knowledgeable observers believe that complete resolution of maldistribution problems will continue to be difficult to achieve in the province. In the interim, however, two key options have evolved: the University of British Columbia Outreach Program and increased use of general practitioners. While these options are not a substitute for areas requiring locally based psychiatrists, they are currently being supported by the ministry to help alleviate some of the problems associated with maldistribution. Both are identified for expansion in Mental Health Services' strategic plan.

Outreach Program

Outreach is funded by Mental Health Services and operated by the University of British Columbia's Department of Psychiatry. It involves attracting psychiatrists, primarily from the lower mainland, to provide regularly scheduled services in underserved areas.

The Outreach Program does help to address geographic maldistribution concerns, and it may be the most cost-effective way to provide a subspecialty (such as child psychiatry) that would not likely exist in a small community. The program can also help to maintain the morale of psychiatrists working in underserved areas.

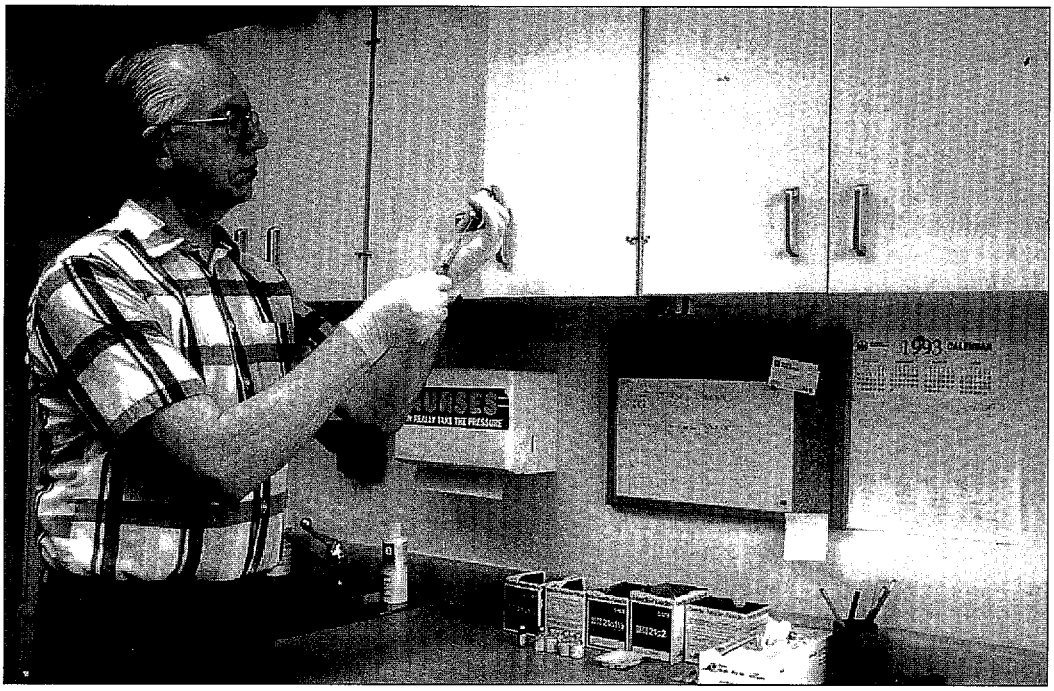
While Outreach is generally seen as a good program by most observers, users have identified some areas for improvement. These include:

- ensuring that the Outreach psychiatrists use their time primarily for consulting with, and teaching, local providers of mental health services;
- striving to have the same psychiatrist visit the same area;
- ensuring effective liaison mechanisms exist between providers and the Outreach psychiatrist;
- further developing arrangements so that the underserved regions have access to lower mainland beds through their Outreach psychiatrist;

- eliminating the overlap in funding arrangements used to obtain Outreach psychiatrists. (Outreach sessions are currently funded by three different organizations—the Outreach Program, Medical Services Plan, and Mental Health Services—but travel costs to get the psychiatrists to the regions is paid out of the Outreach Program's budget. This creates problems if, for example, Mental Health Services or the Medical Services Plan increases sessions in the north, but the Outreach Program does not receive more funding to cover the added travel costs.);
- increasing the overall Outreach funding available, as demand for the program greatly exceeds the funding available;
- using Outreach as an opportunity to expose psychiatric residents-in-training to underserved areas in the hope that they might, in time, learn the skills of community psychiatry and locate there; and
- allocating the Outreach budget to the regions. (Psychiatrists are supplied out of the lower mainland now, but gradually budgets allocated to each region may help to act as an incentive to attract and retain the psychiatrists locally. This is being done for the Child and Youth component of Outreach and indications are that it is having some positive impacts.)

Use of General Practitioners

The second alternative being used to help address the immediate problems associated with psychiatrist accessibility is the greater use of general practitioners. General practitioners are acknowledged by most as the "gatekeepers" to the mental health care system. All of them have



Courtesy of Ministry of Health

A mental health center Psychiatric nurse preparing medication

some training in psychiatry and some have taken additional training; all can prescribe medications. General practitioners are already used extensively in the system and serve a major role by helping to meet the emergency needs of the mentally ill after normal business hours. Some estimates suggest that general practitioners may spend as much as 35% of their time providing mental health related services.

The ministry recognizes the need to train general practitioners to work with the mentally ill. It has been working with the teaching hospitals to provide in-residency courses for general practitioners to expand their knowledge of care of the mentally ill. While additional general practitioner training is viewed by both mental health care providers and the ministry as one of the primary solutions to help reduce the impacts of psychiatrist accessibility problems, the ministry has not fully assessed the extent to which psychiatrist accessibility concerns can be overcome by this option.

We also noted that there are disincentives for general practitioners who are willing to take on greater roles in the mental health care system in smaller communities. For example, the fee-for-service system does not allow billing of the added time a general practitioner might need to consult with the family of seriously mentally ill consumers or with the community for optimal consumer care.

Finally, referral guidelines for use by general practitioners when referring consumers to psychiatrists have not been developed and mutually agreed to by the ministry, psychiatrists, and general practitioners. As a result, individual hospitals, mental health centers, and private practitioners develop their own protocols with their referring general practitioners, but there is no assurance that all of these arrangements are the most appropriate and cost-effective.

Recommendations:

- *The ministry should work closely with the BCMA to find ways to bring about the changes needed to improve psychiatrist accessibility.*
- *The ministry should determine the extent to which disincentives or the lack of incentives in the system contribute to psychiatrist accessibility problems, and take steps to address them.*
- *The ministry should ensure that optimum use is made of the Outreach Program and general practitioners to help improve psychiatrist accessibility.*

In light of the accessibility problems that exist and the difficulties the ministry is having to resolve them, it is crucial that it manages in a way that will help ensure that the resources it currently spends on psychiatrist services are used effectively.

Establishing a Mission and Responsibilities

Psychiatrist services are provided through a complex system involving the ministry, societies funded by the ministry, and several professional groups. Within the ministry, several different groups are involved. To promote accessible, efficient, and effective delivery of psychiatrist services, the ministry needs all providers of these services to be working towards a common goal. This starts with having a mission with clear service priorities and clearly assigned responsibilities.

Conclusion

The ministry needs to clarify its mission and service priorities to help guide service providers. It also needs to ensure that the related authorities required to achieve the mission are established. Overall responsibilities for mental health in the province have been given to the Mental Health Services Division. Service delivery, however, is shared by several major divisions within the ministry, each having its own priorities and funding. The authority needed by Mental Health Services to ensure that all divisions work towards achievement of the mental health mission are not in place. We believe this makes it difficult for Mental Health Services to promote accessible, efficient, and effective mental health care services in the province. On September 29, 1993, the ministry carried out a reorganization that brought the two major providers of mental health services, Acute Care and Mental Health Services, under one branch, Regional Services. This may provide better opportunities for the ministry to establish the needed authorities and to coordinate services for the benefit of the seriously mentally ill.

Findings

Mission Statement

The ministry needs a clear mission statement to outline what it expects to accomplish overall in the area of mental health services. To be effective, the mission statement must be understood by all involved with delivering services.

The 1993 Mental Health Strategic Plan states that the ministry's mental health mission is "to restore, preserve and promote mental health for people of all age groups by ensuring provision of effective and responsive services." The division's policies and procedures manual contains another mission which is "to ensure that the people of British Columbia receive well organized and effective mental health services and that the mentally ill of all ages experience a consistent quality of care." Having two statements creates an element of uncertainty as to what the mission is.

Mission statements are, by their nature, not very specific. To give substance to the mental health mission statement, we think the ministry needs to clearly describe what its service priorities

are. Mental Health Services' policies and procedures manual offers some general guidance, stating that it is division policy to "establish priorities for service as a means of establishing appropriate allocation of resources." Most mental health centers believe that the division wants them to focus services on the seriously mentally ill. However, the manual does not provide a definition of this term. Some people interpret serious mental illness to mean a serious medical illness, like schizophrenia or bi-polar disorder. Others say it can be a less serious medical condition such as stress that is seriously affecting an individual's ability to function. Clearly, common understanding of the term is needed if the ministry is to attain a consistent level of services across the province.

Many providers also believe that the ministry's service priorities should be clearer. At present, regions and local mental health centers, faced with limited resources and with unclear formal guidance, are developing service priorities to meet their local needs as best they can. Some priorities may vary between mental health centers and regions, and this can result in the inefficient use of scarce psychiatrist services.

Although many providers believe that the ministry's plans to regionalize management of health services will have a positive effect on these issues, some are concerned that there is a danger it could lead to a shifting of priorities away from the seriously mentally ill because demand for other services is high. To prevent this possible shift, we think that the ministry needs to maintain a strong role in setting service goals and priorities. Only in this way can it be sure that the seriously ill receive top priority and that the level of services remains consistent across the province.

Establishing Responsibilities

Responsibilities for delivering psychiatrist services in British Columbia are shared through a complex organizational arrangement. Within the ministry, three separate divisions—Mental Health Services, Acute Care, and the Medical Services Plan—have significant responsibilities relating to mental health services. Until recently, Mental Health Services and Acute Care reported to different assistant deputy ministers. The Medical Services Plan reports to the Chairman of the Medical Services Commission (Exhibit 2.6). Each organization has its own mission and budget.

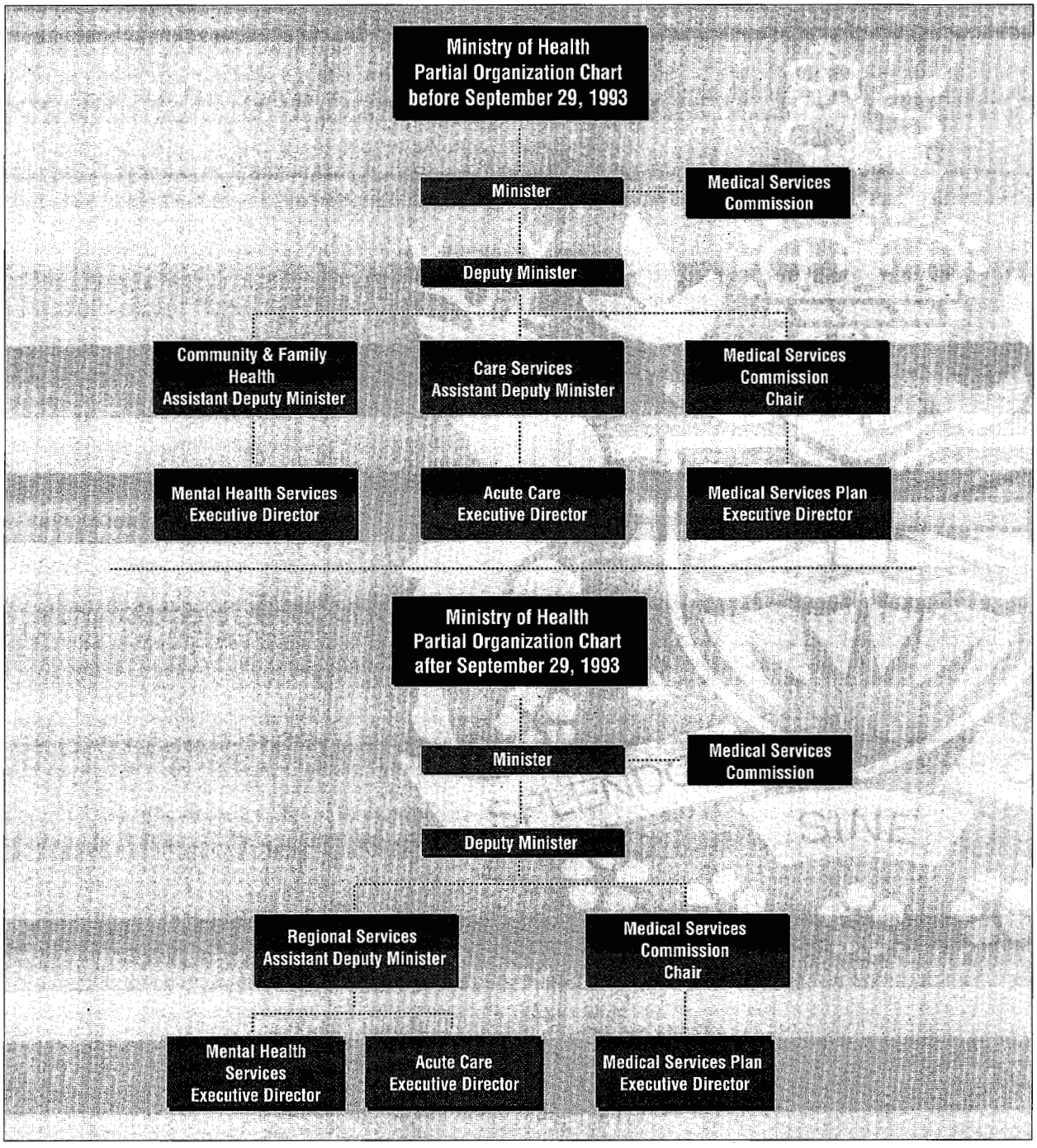
Given that Mental Health Services was established to guide delivery of all mental health services in British Columbia, we expected that it would have the authorities needed to do this. In fact, we found little evidence in the way of organizational lines of authority, control over budgets, reporting requirements, or establishment of service delivery standards to indicate that Mental Health Services has the ability to achieve its mission.

This complex organizational structure may also contribute to the difficulty of attracting psychiatrists to work in the public sector and in underserved areas. Mental Health centers and hospitals sometimes recruit their

Exhibit 2.6

Organization Charts Before and After the Reorganization, September 29, 1993

Charts showing primary parts of the ministry involved with the care of the mentally ill



Source: B.C. Ministry of Health

own psychiatrists independently. We think that this lack of a coordinated recruiting effort by the ministry could deter some prospective psychiatrists who are considering locating in an area. A coordinated recruitment package that offers the prospective psychiatrist the opportunity of setting up a private practice as well as providing services in both the local hospital and mental health center would likely be more appealing professionally.

On September 29, 1993, the ministry started a reorganization to bring Acute Care and Mental Health Services under one branch called Regional Services, reporting to a single assistant deputy minister (Exhibit 2.6). While there are still two organizational units, the fact that they are both the responsibility of one individual holds, in our opinion, potential for establishing the needed authorities and improving the operation of the mental health system in British Columbia. Some mental health care providers are optimistic that this will be an improvement over the former organizational arrangement, and that it may help to improve psychiatrist accessibility.

Recommendation:

- *The ministry should ensure that it has a clear mission and clear service priorities for mental health services in the province and that responsibilities and related authorities necessary to achieve the mission are established.*

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Establishing Objectives and Standards

Properly managing the delivery of psychiatrist services in the province requires more than a well-defined mission statement and clearly assigned responsibilities. The ministry also needs a basis for determining what services are needed in each area of the province and how it can best deliver them.

Foremost, the ministry needs clear objectives and standards so that all providers understand the degree of access the ministry expects to achieve. This requires that the ministry define and prioritize when psychiatrist services are required. This, in turn, will help the ministry determine how those services should be provided, how many psychiatrists are needed, and which areas of the province require either more or fewer psychiatrists.

Conclusion

Historically, psychiatrist services have evolved in each area of the province, not based on established long-term needs and ministry-defined objectives and standards, but on factors such as historical service utilization levels, prior year budgets, and psychiatrists' choice of location. The ministry recognizes that this has led to psychiatrist accessibility problems and has started to establish long-term objectives for mental health care services needed around the province, including psychiatrist services. However, further work is needed. The ministry also needs to clearly define service standards, to help guide and prioritize access to psychiatrists in both public sector facilities and private practices.

Findings

Objectives

In the past, the level of access to psychiatrist services was based on demand and utilization levels. If demand and utilization were high, it was presumed that there continued to be unmet needs and that there was room for even more services. This approach, however, does not provide a good basis for cost-effectively managing the provision of psychiatrist services with due regard to the principle of equitable access. For example, the lower mainland already has a high number of psychiatrists relative to other parts of the province. However, many providers believe that demand for services is so strong in that area that even if the number of psychiatrists increased dramatically, there would still be waiting lists. As a result, they see a need for the ministry to take a greater role in prioritizing access to psychiatrist services in the province.

To help ensure that there is equitable access throughout the province and that limits are set on services and costs, the ministry first needs to establish service objectives based on an analysis of the mental health care needs of the population.

The ministry has started such an analysis. In February 1993, it

published *The Provincial Mental Health Benchmarks*, a document that includes some information about the nature and extent of mental disorders in British Columbia and analyzes mental health services provided to the adult population. In time, the ministry plans to use it as a basis for establishing long-term objectives for mental health services in British Columbia.

The *Benchmarks* document is acknowledged by the ministry to apply only on a provincial basis because it does not reflect regional differences. Further work is expected to include developing a means to factor in these differences. As well, the benchmarks themselves will continue to evolve after pilot testing.

In the absence of long-term objectives and a complete needs analysis, emphasis has been placed on psychiatrist-to-population ratios as a way of estimating psychiatrists needed in an area of the province. The most commonly accepted ratio used is that developed by the World Health Organization: 1 psychiatrist per 10,000 population. This ratio does have some limitations, however. Mainly, it does not reflect actual needs in an area and it does not provide guidance as to the many subspecialties of psychiatry (such as child, geriatric, and forensic psychiatry) which may be needed in a particular geographic area.

Once the ministry has complete information about the nature and extent of mental disorders in the province and has established its long-term objectives, it then needs to define access standards. These should be designed to ensure that the service levels required to meet its objectives are available at the appropriate times and in the appropriate places.

Access Standards

Well-defined accessibility standards are needed by the ministry to help guide its activities, to provide a basis against which it can assess how well it is performing, and to help it determine what adjustments are needed in the number of psychiatrists in each area of the province. Standards can also help to promote consistency in the degree of access to services provided in the province.

Psychiatrist access standards can be defined in many ways. For example, access might be defined in terms of the broad World Health Organization standard of 1 psychiatrist per 10,000 population in a defined region of the province. A more sophisticated approach might be to have different ratios in different parts of the province, depending on the incidence of mental illnesses. Access could also be defined in terms of the type of services that can be provided, in terms of distance between consumers and needed psychiatrist services, or in terms of hours of coverage. For example, ministry policy might state that any consumer requiring services at a designated regional hospital or mental health center should be seen by a psychiatrist within 24 hours.

The ministry, however, has not adequately addressed the issue of psychiatrist accessibility

standards. It does not define access standards well for its mental health centers, and it does not play a strong role in the review and approval of the access standards used by the other providers of psychiatrist services—general hospitals, Riverview Hospital, the Greater Vancouver Mental Health Services Society, and psychiatrists in private practice.

Mental Health Service Centers

Consumers come to ministry-operated mental health centers as a result of general practitioner or private psychiatrist referrals, or of self-referral. To guide the centers in providing services to its consumers, Mental Health Services has provided them with the *Clinical Policies and Procedures Manual.* The manual defines clinical service standards to help ensure a degree of consistency in the delivery of services around the province. It does not, however, define access standards well. Service priorities are not clear and the standards are not specific as to when services must be provided by a psychiatrist. The policies contained in the manual are vague and state that the services provided by the psychiatrist should be determined based on the time available.

The Mental Health Services Division has recently created the position of Regional Clinical Director in each region of the province. The positions have been filled by psychiatrists and the division expects these individuals to help define standards of service and the number of psychiatrists needed within each of their regions. Most providers see the Regional Clinical Director positions as a positive development by the division, although job descriptions have not yet been confirmed and funding for the positions has not been fixed so that the positions can be considered permanent.

General Hospitals

Consumers arrive in hospitals as the result of many different circumstances. They may be referred by general practitioners or private psychiatrists; or they may arrive as the result of an episodic incident in which, for example, police or ambulance services have been called and they recognize that mental illness may be involved.

Acute Care provides broad service standards to hospitals. Within these broad guidelines, individual hospitals define their own standards for access to psychiatrist services in terms of their specific needs, circumstances, and resources. Some hospitals develop psychiatrist needs based on performance standards and caseloads. However, with limited sessional funding and limited availability of psychiatrists, the psychiatrist's role generally tends to be defined in terms of time available. There is no formal and ongoing requirement for Mental Health Services to approve the psychiatrist access standards being applied by hospitals.

Riverview Hospital

Consumers referred to Riverview Hospital are, in general, people with severe mental illnesses who require the services of a tertiary level hospital. Riverview has been developing a process for

estimating the number of psychiatrists it needs. The approach it is taking is to look at psychiatrist requirements in terms of the services the psychiatrists should perform. The process attempts to factor in the number of patients, based on the nature and severity of their illness, who require psychiatrist services, the number of patients who will require services during a defined time period, and the length of time it should take a psychiatrist to perform those services.

Recently, the Director of Psychiatric Services of the Mental Health Services Division was asked by the Medical Services Plan (which must approve any increases in psychiatrist sessions) to review Riverview's plans for psychiatry. However, there is no formal requirement for Mental Health Services to review and approve Riverview's access standards.

Greater Vancouver Mental Health Services Society

The Greater Vancouver Mental Health Services Society provides the community mental health center services for Vancouver and Richmond. Its consumers arrive there for similar reasons that consumers use Mental Health Services' centers. The Society has developed some performance standards relating to the use of psychiatrists based on caseloads. For example, they have a policy that every consumer is to be seen by a psychiatrist and that each psychiatrist, working on a full-time sessional basis, is expected to carry a defined caseload. As with Riverview Hospital, the Society also defines the role of its psychiatrists in terms of the services they should perform.

There is no requirement, however, for Mental Health Services to review and approve the Society's access standards to ensure a consistent standard of care throughout the community mental health system.

Private Sector Psychiatrists

Consumer access to private psychiatrists depends on the following factors:

Courtesy of Ministry of Health

A Greater Vancouver Mental Health Services Society team working in New Westminster

- referral by a general practitioner;
- the supply of psychiatrists in a defined area and the length of their waiting lists;
- the suitability of the consumer for treatment under the preferred pattern of practice of each individual psychiatrist; and
- whether the consumer is covered under the Medical Services Plan.

Guiding the services provided by private practice psychiatrists poses a significant challenge to the ministry in its attempts to achieve its goals. While the ministry may want to ensure that priority is given to treating the seriously mentally ill, it currently has limited ability to do this within private practices even though a large portion of ministry spending on psychiatry occurs there. Psychiatrists are entitled to bill for any service that qualifies under the Medical Services Plan and the plan does not prioritize illnesses or degree of severity. Any change to this arrangement requires the cooperation and support of the BCMA.

Once an individual is accepted as a client of a private psychiatrist, services can be legitimately provided for an unspecified length of time under the Medical Services Plan. One service provided mostly by psychiatrists in private practice is psychotherapy. Psychotherapy is defined as a relationship between a psychiatrist and a consumer in which talking is the primary mechanism for promoting insight and thereby a change in behavior. A report on mental health care services in British Columbia prepared under the guidance of Dr. E. Fuller Torrey in the spring of 1993, noted that there are large numbers of psychiatrists in Vancouver and Victoria whose practice consists almost exclusively of providing psychotherapy and counseling to individuals who do not have serious mental illnesses.

Many providers are concerned that psychotherapy services consume a large amount of scarce funding and are not directed towards the seriously mentally ill. Some Canadian and United States jurisdictions have looked at placing restrictions on psychotherapy as an insured service. In British Columbia there are already some restrictions on this service but, in our opinion, not enough to ensure that the balance between resources for those who are seriously mentally ill and for those who are not is consistent with the ministry's goals.

Recommendations:

- *The ministry should establish clear objectives and well-defined service standards for access to psychiatrist services. These objectives and standards should be based on an analysis of the long-term mental health needs of the population.*
- *The ministry should work with all providers of mental health services to ensure that all services provided are consistent with the ministry's overall mental health goals.*

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Monitoring and Reporting

To help ensure that psychiatrist services are accessible, the ministry also needs to receive adequate information to enable it to evaluate whether its objectives are being met.

Given Mental Health Services leadership role, we expected it to be gathering information from all providers of mental health services and evaluating whether the ministry's accessibility objectives are being met.

We wanted to ascertain whether the form, content, and frequency of monitoring information required by the division from all providers had been defined. We also wanted to assess whether the information reporting requirements were being met and whether the information required and received by the division was adequate. We were particularly interested in these issues as they pertain to psychiatrist accessibility.

Conclusion

We concluded that the ministry does not have an adequate system to collect information about services provided by hospital psychiatric unit programs, community mental health centers, and private psychiatrists. As a result, it does not have complete and reliable information about the extent of mental illness and the availability of psychiatry services in each region of the province. It also lacks information to assess whether scarce psychiatrist resources are being applied to the highest priority cases and whether they are being provided cost-effectively. The ministry recognizes that its information system for mental health services is inadequate and has a goal to develop an improved system within the next few years. Consumer confidentiality is one important issue that the ministry needs to resolve if it is to gather the information it needs to effectively manage mental health services.

Findings

Monitoring is an essential management tool. Given scarce mental health care resources—particularly psychiatrist services—in several areas of the province, management and public decision-makers need to know that the resources are being used to produce the greatest benefits. Furthermore, because significant amounts of public funds are being spent, information is needed to help demonstrate accountability.

Several aspects of the system should be monitored. One is the spending of funds, or "input," to help the ministry ensure that funds are being used for approved activities and that overspending does not occur. Another is "outputs" such as the types and number of cases handled by each mental health center, hospital, and private practice psychiatrist. These can be analyzed to help the ministry assess whether resources are being efficiently used. A third is "outcomes," or what is being achieved with the funds spent.

Monitoring Resources Used and Outputs Achieved

The Mental Health Services Division has defined its information requirements and receives information it uses to monitor its mental health centers' use of financial resources and their outputs. Financial information is provided by way of the ministry's financial management reports. The division also operates a Client Registry System which requires that each mental health center provide personal client information, referral source, and diagnostic information for entry into the centralized system.

Many centers, however, do not find the Client Registry System very useful for monitoring purposes. There are several reasons. Certain information, such as referrals deflected to other services and services provided under contract, are not included. The reports are produced only quarterly, so the system is not timely as a monitoring tool. Also, the system does not produce any direct information to help the ministry assess whether psychiatrist services are being used to produce the greatest benefits. The information currently being collected by the division does not adequately describe the state of psychiatrist services in mental health centers, such as psychiatrist services available, services required, and centers with either excessive or inadequate levels of services.

The division's services are only part of the mental health services provided by the ministry. To have a complete picture, the division needs information from private practice psychiatrists and from all parts of the ministry providing mental health services. It has not, however, defined the information it requires from these parties and there is no regular

Courtesy of Ministry of Health

A mental health centre multidisciplinary team conducting a case review

sharing of information between them. As a result, finding information in the ministry that provides a complete picture of the state of mental health services in the province is difficult. This is consistent with observations made in the ministry's *Benchmarks* document which states that "the greatest obstacle in preparing the document was the lack of current and accurate utilization and capacity information." We think this situation reduces the ministry's ability to monitor and be accountable for mental health services overall and for psychiatrist services specifically. The Mental Health Services Division recognizes the inadequacies of the present information system and has indicated a desire to improve it over the next few years.

An important issue that arises in connection with the ministry's desire to improve its information is patient confidentiality. The ministry has found that services provided to consumers in institutional and community facilities is generally protected so as to maintain confidentiality and comply with professional and organizational policies. This issue has to be overcome for the ministry to gather the information it needs to manage the mental health system effectively.

Having adequate information does not guarantee that the results the ministry intends to achieve with its spending on mental health services will be achieved. Ensuring results are achieved requires processes designed to evaluate whether the ministry is being effective with its spending and attempting to identify where improvements can be made.

Monitoring Effectiveness

Evaluation of the effectiveness of mental health care activities in the ministry is not well developed. Most providers review research reported in medical journals and consult with colleagues to help ensure that they are using current techniques and medications and being efficient and effective. Some regions conduct operational reviews of mental health centers within the region using a group made up of members from the centers and the regional office. These reviews are helpful to promote consistency and efficiency among mental health centers, but they do not provide a complete insight into the overall provincial system. Recently, the ministry has conducted a few reviews which take a more complete look at the cohesiveness of the services provided in an area.

Many providers acknowledge that there is a need for the ministry to increase its evaluation activities. One way would be to have the ministry undertake an independent evaluation of the University of British Columbia Outreach Program to assess its effectiveness, need for improvement, and scope for expansion. Similar evaluation work should be done on the ministry's isolation bonus program to assess how effective it is at attracting and retaining psychiatrists in underserved areas.

Psychiatrists are used in both mental health centers and hospitals, but in different ways. We believe that mental health

centers and hospitals individually attempt to ensure that they make the best use of their psychiatrist services. However, partly because they are organizationally independent of each other, the ministry cannot be certain that within an area or region they operate in a coordinated fashion. We noted one area using a model which works to coordinate all the services (hospital, mental health center, private psychiatrists, general practitioners) provided in their community. A committee made up of representatives from the groups involved determines how and where each patient's needs can be most efficiently and effectively met. We believe this model has the potential to improve the delivery of mental health services and the use of psychiatrists. We think it should be evaluated and its key elements clearly defined, including the roles and responsibilities of the members involved. If the results are positive, the ministry should strive to implement it throughout the province.

A more complex but potentially insightful evaluation activity would be to establish health assessment baseline data. The ministry could then periodically evaluate whether it is having a positive effect on the percentage of the population suffering from mental illness, and whether hospital use is declining for mental health care consumers. Such information could help the ministry decide whether certain treatment programs should continue or others be increased.

Recommendation:

- *The ministry should develop, as soon as possible, a system that will allow it to gather the information needed to monitor and evaluate the extent to which its objectives are being met.*

Reporting to the Legislative Assembly

Accountability is needed so that the legislature can hold the government responsible for achieving public policy objectives delegated to them and for effectively managing the resources given to them for this purpose. Accountability is essential in the case of psychiatrist services, because those services directly affect the achievement of the ministry's mission and they consume a large amount of public funds. Accountability was also raised as a key issue in the report of the *Royal Commission on Health Care and Costs*.

We expected the ministry's annual reports to provide sufficient information to the legislature and the public about its progress towards meeting its objectives for psychiatrist services. Our audit examined how well the ministry reports on these matters to the Legislative Assembly.

Conclusion

The ministry has not provided the public and the legislature with adequate information about the extent to which it has been able to meet its objectives for psychiatrist services.

Findings

Achieving good accountability is not easy. It requires a clear definition of what the ministry is expected to achieve and good information sources so that the ministry is in a position to report on how well it has performed. As noted earlier, the ministry has not clearly defined its overall mission or established clear objectives for the provision of mental health services. Furthermore, it has not gathered information about the mental health services delivered throughout the province. As a result, it is not in a position at this time to provide good accountability information to the legislature.

Our review of the ministry's most recent annual report covering activities for the 1991/92 fiscal year shows a brief description about Mental Health Services and a limited amount of financial and statistical information. However, there is very little information about the ministry's activities and accomplishments in the mental health care area, or about the overall state of mental health in the province. Although the ministry has developed information about psychiatrist accessibility problems and has attempted to deal with these matters, this information has not been included in its public reporting.

Recommendation:

- *The ministry should provide the Legislative Assembly with information about the extent to which the ministry has been able to meet its objectives for psychiatrist services.*

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Ministry Response

The Ministry of Health welcomes the Auditor General's Report on the Value-for-Money Audit of Psychiatrist Services and appreciates the very thorough and professional manner in which the audit was conducted. The Ministry accepts the findings noted in the Report and will work closely with the British Columbia Medical Association to ensure that the recommendations are fully implemented.

It is most important for all concerned that persons with serious mental illnesses have ready access to needed psychiatrist services throughout the province. The Ministry of Health is strongly committed to making the changes necessary to ensure that this occurs, and that related management accountability processes are improved.

With regard to the eight specific recommendations in the Report, the Ministry has the following comments:

Recommendation 1: Work with the BCMA to Improve Psychiatrist Accessibility

The Ministry supports this recommendation and has recently established a joint committee with the BCMA to address the issue of psychiatrist accessibility. The Joint Committee to Lead the Provision of Psychiatric Services in British Columbia will function as a Temporary Advisory Sub-Committee to the Professional Advisory Committee which the Ministry of Health and the BCMA maintain. The Chair and other members of the Committee have been named, and terms of reference have been agreed.

Recommendation 2: Address Disincentives or the Lack of Incentives to Psychiatrist Accessibility

The Ministry supports this recommendation and will be working with the BCMA to consider the issue of disincentives and lack of incentives as part of the Joint Committee review.

Recommendation 3: Ensure Optimum Use Is Made of the Outreach Program and General Practitioners

The Ministry supports this recommendation, and has expanded the Psychiatric Outreach Program over the past several years as a cost-effective way of delivering specialized psychiatrist consultation services to remote and under-serviced areas of the province. Now managed by the Cooperative University/Provincial Psychiatric Liaison (CUPPL) Program, funded by the Ministry of Health through the Department of Psychiatry at the University of British Columbia, the Outreach Program has long been a leader in developing and delivering specialized psychiatric training to general practitioners throughout the province.

Recommendation 4: Develop a Clear Mission and Priorities for Mental Health Services, and Establish the Responsibilities and Authorities Needed to Achieve Them

The Ministry supports this recommendation, and is currently developing a Policy Framework for Persons with Mental Illness as part of the implementation of the New Directions in Health Initiative. In addition to a Vision, Mission and Themes which are shared by all

Ministry programs, the Policy Framework will clarify specific Guiding Principles, Key Issues, Recommended Strategies and Priority Actions relating to mental health services for Community Health Councils and Regional Health Boards as they assume their new responsibilities for health service delivery throughout the province over the next few years. The CHCs/RHBs will have the authority under the Health Authorities Act which they need to discharge their responsibilities effectively.

Recommendation 5: Establish Clear Objectives and Standards for Psychiatrist Services Based on Long-Term Population Needs

The Ministry supports this recommendation, and will be addressing this in collaboration with the BCMA through the Joint Committee process. The Provincial Mental Health Benchmarks will be further refined to provide resource capacity guidelines for all mental health services, and core services and practice standards will be developed for psychiatrist services and other mental health services as part of the implementation of New Directions in Health.

Recommendation 6: Work with All Service Providers to Ensure Consistency with Overall Mental Health Goals

The Ministry supports this recommendation, and will be addressing this with the BCMA through the Joint Committee process to ensure that all psychiatrist services funded by the Ministry are consistent with overall mental health goals, and particularly with the priority to those with serious mental illnesses.

Recommendation 7: Develop an Information System to Ensure Objectives are Being Met

The Ministry supports this recommendation, and is planning to develop an improved information system within the next few years which will aggregate data from hospital psychiatric programs, community mental health centers/community care teams, and private psychiatrists. A key feature of any such system will be its ability to safeguard the confidentiality of consumers within the context of the Freedom of Information and Protection of Privacy Act.

Recommendation 8: Provide the Legislative Assembly with Information about the Extent to which the Ministry has Met its Objectives for Psychiatrist Services

The Ministry supports this recommendation, and will include in its Annual Report a section reporting on the accessibility of psychiatrist services in the province.

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Appendices

Appendices

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- The Transfer of Patients from Riverview Hospital to the Community
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Ministry of Government Services:

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Ministry of Attorney General:

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Appendix B

Office of the Auditor General: Audit Objectives and Methodology

Audit work performed by the Office of the Auditor General falls into three broad categories:

- Financial statement auditing;
- Value-for-money auditing; and
- Compliance-with-authorities auditing.

Each of these categories has certain objectives that are expected to be achieved, and each employs a particular methodology to reach those objectives. The following is a brief outline of the objectives and methodology applied by the Office for value-for-money auditing.

Value-for-Money Auditing

Purpose of Value-for-Money Audits

Value-for-money audits look at how organizations have given attention to value for money—to economy, efficiency and effectiveness.

The concept of value-for-money auditing is based on two principles. The first is that public business should be conducted in a way that makes the best possible use of public funds. The second is that people who conduct public business should be held accountable for the prudent and effective management of the resources entrusted to them.

The Nature of Value-for-Money Audits

A value-for-money audit has been defined as:

> *. . . the independent, objective assessment of the fairness of management's representations on performance, or the assessment of management systems and practices, against criteria, reported to a governing body or others with similar responsibilities. .*

This definition recognizes that there are two primary forms of reporting used in value-for-money auditing. The first—referred to as attestation reporting—is the provision of audit opinions on reports that contain representations by management on matters of economy, efficiency and effectiveness.

The second—referred to as direct reporting—is the provision of more that just auditor's opinions. In the absence of representations by management on matters of economy, efficiency and effectiveness, auditors, to fulfill their mandates, gather essential information with respect to management's regard for value for money and include it in their own reports along with their opinions. In effect, the audit report becomes a partial substitute for information that might otherwise be provided by management on how they have discharged their essential value-for-money responsibilities.

The attestation reporting approach to value-for-money auditing has not been used yet in

British Columbia because the organizations we audit have not been providing comprehensive management representations on their value-for-money performance. Indeed, until recently, the management representations approach to value for money was not practicable. The need to account for the prudent use of taxpayers' money had not been recognized as a significant issue and, consequently, there was neither legislation nor established tradition that required public sector managers to report on a systematic basis as to whether they had spent taxpayers' money wisely. In addition, there was no generally accepted way of reporting on the value-for-money aspects of performance.

Recently, however, considerable effort has been devoted to developing acceptable frameworks to underlie management reports on value-for-money performance, and public sector organizations have begun to explore ways of reporting on value-for-money performance through management representations. We believe that management representations and attestation reporting are the preferred way of meeting accountability responsibilities and are actively encouraging the use of this model in the British Columbia public sector.

Presently, though, all of our value-for-money audits are conducted using the direct reporting model, therefore, the description that follows explains that model.

Our value-for-money audits are not designed to question government policies. Nor do they assess program effectiveness. The *Auditor General Act* directs the Auditor General to assess whether the programs implemented to achieve government policies are being administered economically and efficiently. Our value-for-money audits also evaluate whether members of the Legislative Assembly and the public are provided with appropriate accountability information about government programs.

When undertaking value-for-money audits, auditors can look either at results, to determine whether value for money is actually achieved, or at managements' processes, to determine whether those processes should ensure that value is received for money spent.

Neither approach alone can answer all the legitimate questions of legislators and the public, particularly if problems are found during the audit. If the auditor assesses results and finds value for money has not been achieved, the natural questions are "Why did this happen?" and "How can be prevent it from happening in future?" These are questions that can only be answered by looking at the process. On the other hand, if the auditor looks at the process and finds weaknesses, the question that arises is "Do these weaknesses result in less than best value being achieved?" This can only be answered by looking at results.

We try, therefore, to combine both approaches wherever we can. However, as acceptable results information and criteria are often not available, our value-for-money audit work frequently concentrates on managements' processes for achieving value for money.

We seek to provide fair, independent assessments of the quality of government administration. We conduct our audits in a way that enables us to provide positive assessments where they are warranted. Where we cannot provide such assessments, we report the reasons for our reservations. Throughout out audits, we look for opportunities to improve government administration.

Audit Selection

We select for audit either programs or functions administered by a specific ministry or public body, or cross-government programs or functions that apply to many government entities. There are a large number of such programs and functions throughout government. We examine the larger and more significant ones on a cyclical basis.

We believe that value-for-money audits conducted using the direct reporting approach should be undertaken on a five- to six-year cycle so that members of the Legislative Assembly and the public receive assessments of all significant government operations over a reasonable time period. Because of limited resources, we have not been able to achieve this schedule.

Our Audit Process

We carry out these audits in accordance with the value-for-money auditing standards established by the Canadian Institute of Chartered Accountants.

One of these standards requires that the "person or persons carrying out the examination possess the knowledge and competence necessary to fulfill the requirements of the particular audit." In order to meet this standard, we employ professionals with training and experience in a variety of fields. These professionals are engaged full-time in the conduct of value-for-money audits. In addition, we often supplement the knowledge and competence of our own staff by engaging one or more consultants, who have expertise in the subject of that particular audit, to be part of the audit team.

As value-for-money audits, like all audits, involve a comparison of actual performance against a standard of performance, the CICA prescribes standards as to the setting of appropriate performance standards or audit criteria. In establishing the criteria, we do not demand theoretical perfection from public sector managers. Rather, we seek to reflect what we believe to be the reasonable expectations of legislators and the public. The CICA standards also cover the nature and extent of evidence that should be obtained to support the content of the auditor's report, and, as well, address the reporting of the results of the audit.

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