

# Chapter 1

## Section 1.12

Ministry of Health and Long-Term Care

# Specialty Psychiatric Hospital Services

Follow-Up on VFM Section 3.12, 2016 Annual Report

RECOMMENDATION STATUS OVERVIEW						
	# of Actions Recommended	Status of Actions Recommended				
		Fully Implemented	In Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	3		2	1		
Recommendation 2	1		1			
Recommendation 3	3			3		
Recommendation 4	3		1	2		
Recommendation 5	1	1				
Recommendation 6	3			3		
Recommendation 7	2	2				
Recommendation 8	4	4				
Recommendation 9	1	1				
Recommendation 10	2		2			
Recommendation 11	1		1			
Recommendation 12	3	1	1	1		
Recommendation 13	2	2				
Recommendation 14	3		3			
Recommendation 15	2	2				
<b>Total</b>	<b>34</b>	<b>13</b>	<b>11</b>	<b>10</b>	<b>0</b>	<b>0</b>
<b>%</b>	<b>100</b>	<b>38</b>	<b>32</b>	<b>30</b>	<b>0</b>	<b>0</b>

## Overall Conclusion

As of August 3, 2018, 38% of the actions we recommended in our 2016 Annual Report had been fully implemented, specifically in the areas

of reviewing hospitals' care planning policies to ensure alignment with best practices, developing quality standards related to mental health services, and establishing a forum for information sharing among hospitals. Thirty-two percent of the actions we recommended were in the process of being

implemented, mainly in the areas of developing a consistent way to measure wait time information from hospitals, collecting wait time information for in-patient and out-patient programs, and determining the number of long-term psychiatric beds needed in each region. Thirty percent of the actions we recommended had little or no progress. They were in the areas of determining the number of long-term psychiatric beds needed in each region of the province, developing mental health standards related to admission, treatment and discharge of patients and requiring specialty psychiatric hospitals to follow such standards.

The Ministry of Health and Long-Term Care (Ministry) indicated that the change in government has required new policy development to align with the articulated priorities and funding commitments of the new government. Though the Ministry has continued to move forward on foundational work, implementation of a new policy framework and investments has been extended during this transition.

The Ministry is exploring policy options regarding multi-year mental-health and addictions initiatives tied to the \$3.8-billion provincial and federal commitment to build a comprehensive mental-health and addictions system. The Ministry expects that these initiatives, once implemented, will address a number of our recommendations.

The status of the actions taken on each of our recommendations is described in this report.

## Background

Across Ontario, there are about 2,760 long-term psychiatric beds in 35 facilities (primarily hospitals). These beds are for children, adults and seniors who need treatment for the most severe or complex forms of mental illness. The beds are also for forensic patients—people who have, or are suspected of having, mental illness and who have been charged with a criminal offence.

About half (1,389) of these beds are located in four hospitals, called specialty psychiatric hospitals, that primarily provide mental health care. Our audit focused on these four hospitals: Centre for Addiction and Mental Health (CAMH) in Toronto; Ontario Shores Centre for Mental Health Sciences (Ontario Shores) in Whitby; The Royal Ottawa Health Group (The Royal) with sites in Ottawa and Brockville; and Waypoint Centre for Mental Health Care (Waypoint) in Penetanguishene.

In 2017/18, these four specialty psychiatric hospitals treated about 7,700 patients (7,200 in 2015/16) and handled about 346,000 visits from out-patients (280,000 in 2015/16).

The Ministry of Health and Long-Term Care (Ministry) is responsible for providing overall direction, funding and leadership for mental health care in Ontario. The Ministry provides funding to 14 regional Local Health Integration Networks (LHINs) responsible for planning and integrating health services in their respective region. LHINs enter into an accountability agreement with specialty psychiatric hospitals and provide funding to them.

In 2016/17, specialty psychiatric hospitals received \$615 million (\$673 million in 2015/16), which represents over 17% of the about \$3.6 billion the Ministry spent in total on mental health care (\$3.3 billion in 2015/16).

We found that the Ministry and LHINs focused less on specialty psychiatric hospitals compared with other areas of health care, such as general hospitals. For example, the Ministry collected wait time information and funded general hospitals based on the demand for their services, but it did not do this for specialty psychiatric hospitals.

Some of our significant observations included:

- Wait times for patients to receive treatment were long and getting longer. In 2015/16, children had to wait more than three months to receive help at Ontario Shores for severe eating disorders. At Waypoint, the wait list for one of the main out-patient programs was so long that in 2015/16, the hospital temporarily stopped adding new people to the wait list.

- In the five years prior to our audit, approximately one in 10 beds in specialty psychiatric hospitals was occupied by patients who no longer needed to be treated in the hospital but could not be discharged due to the lack of available beds in supportive housing or at long-term-care homes. The cost of care there is less than one-fifth of what it is at specialty psychiatric hospitals.
- Some regions lacked long-term psychiatric beds. Beds dedicated for individuals with addictions were only available in six of the 14 LHINs. The lack of needed care resulted in the Ministry spending almost \$10 million between 2011/12 and 2015/16 to send 127 youths to the United States so that they could receive needed treatment.
- Between 2011/12 and 2015/16, there was a net reduction of 134 long-term psychiatric beds across the province. Thirty-two of those long-term beds that were closed were at specialty psychiatric hospitals due to the limited increase in funding.
- During our audit, the Ministry increased funding for specialty psychiatric hospitals by 2%. This increase was not supported by actual demand for specialty psychiatric services; nor did it target programs that had the biggest wait lists for treatment. Without mental health targets and relevant information, the Ministry and LHINs could not make effective funding decisions.
- A sample of patient files we reviewed at two of the specialty psychiatric hospitals were updated late or missing important information.
- The hospitals were increasing their use of part-time staff. The mix of full-time and part-time staff varied between the hospitals, and none had a target for this mix.
- The hospitals spent less money on direct patient care than other comparator hospitals and their spending had decreased. Since 2011/12, specialty psychiatric hospitals' spending on direct patient care had decreased by 2 cents, from 64 cents to 62 cents in 2015/16, out of every dollar that they received from the Ministry. This was 5% less (3 cents) than the average of 65 cents that other comparator hospitals in Ontario spent on direct patient care.
- CAMH had the only emergency department in Ontario that was exclusively for people experiencing mental health issues. The Ministry had no plans to create additional ones.
- In 2014, Waypoint opened a new building to house its high-security forensic program. Since then, 90 deficiencies affecting staff and patient safety were identified. As a result of several hospital staff being assaulted and injured, including one who was stabbed by a patient, the Ministry of Labour was called in and issued seven compliance orders to address safety issues that occurred in the new building.
- Each of the four specialty psychiatric hospitals developed their own standards pertaining to patient admission, treatment and discharge. These standards could differ, resulting in differences of how patients with the same diagnosis were regarded by each hospital.
- Specialty psychiatric hospitals were implementing new treatment methods to better treat certain mental illnesses. However, we found that there was no process for hospitals to share new treatment methods developed by their peers.
- Only one LHIN had a database whereby all providers of mental health services could look up patients' information to identify all the care and services those patients were receiving. A similar problem existed with the sharing of patients' information with the police. Police told us that some hospitals were not willing to share patient information, mainly because under the *Personal Health Information Protection Act*, personal

health information cannot be shared without express consent of the patient. Without this information, the police had to assume patients who left without authorization from specialty psychiatric hospitals posed a high risk of danger to the public, which could lead to a greater use of force.

We made 15 recommendations, consisting of 34 action items, to address our audit findings.

We received commitment from the Ministry and LHINs that they would take action to address our recommendations.

## Status of Actions Taken on Recommendations

We conducted assurance work between April 1, 2018, and August 3, 2018. We obtained written representation from the Ministry of Health and Long-Term Care (Ministry), Local Health Integration Networks (LHINs) and specialty psychiatric hospitals that, effective October 31, 2018, they have provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

### Patients Suffering from Longer Waits

#### Recommendation 1

*In order to ensure Ontarians know how long they need to wait for specialty psychiatric hospital services, the Ministry of Health and Long-Term Care should:*

- as soon as possible develop a consistent way to measure wait time information from specialty psychiatric hospitals;

**Status:** In the process of being implemented by the end of March 2021.

#### Details

Our 2016 audit found that while the Ministry collected and publicly reported wait times for a number of services offered at general hospitals, it had not developed a consistent way for specialty psychiatric hospitals to measure or report wait time information.

During our follow-up, we found that the Ministry, in partnership with the specialty psychiatric hospitals, has introduced an Access to Care initiative, which aims to use hospital data to track specific wait times, identify service gaps, and build a structure for public reporting and accountability. Funding for the Access to Care initiative is to be provided until December 2018 to refine wait-time indicators, initiate benchmarking activities, and improve data quality.

The Ministry has also started to standardize definitions of wait times in the mental health and addictions sector. Performance measurement work is expected to continue until the end of March 2021. Examples of some of the work to be completed in 2018/19 include:

- integrating community mental health and addictions screening and assessment data into one system;
- developing and tracking a new indicator on hospital readmissions within 30 days related to mental health and addictions; and
- using the Ministry-funded Adult Mental Health Scorecard published by the Institute for Clinical and Evaluative Sciences (ICES) as one of the key references to develop a provincial approach for measuring performance and wait times related to mental health and addictions.

- collect wait time information for in-patient and out-patient programs;

**Status:** In the process of being implemented by December 2018.

### Details

Our 2016 audit found one of the most significant consequences of longer wait times was the potential of persons harming themselves. Since 2011, Ontario Shores and The Royal were aware of seven people who died while waiting for a bed or an out-patient program.

As previously mentioned, the Ministry, in partnership with the specialty psychiatric hospitals, has worked on the Access to Care initiative to track specific wait times in order to provide the Ministry, hospitals and LHINs with information for making decisions and improving service delivery. The Ministry expects that the Access to Care initiative will be completed by December 2018.

- *publicly report this information.*  
**Status: Little or no progress.**

### Details

Our 2016 audit found a lack of public reporting on wait times for mental health services at specialty psychiatric hospitals, which decided what they wanted to report.

During our follow-up, we noted that wait-time information for in-patient and out-patient programs has not been publicly reported, as the Ministry is still in the early stage of collecting and measuring wait-time information. As mentioned above, the Ministry-funded ICES's Adult Mental Health Scorecard contains an indicator that measures wait times from referral to service initiation. The ICES and the Ministry will continue to monitor mental health and addictions system performance and will publish a scorecard report in two years' time. This will also entail developing common definitions for wait times.

The Ministry also informed us that in July 2018, it announced a commitment to invest \$1.9 billion to match the federal government's contribution, for a total of \$3.8 billion over the next 10 years to build a comprehensive mental health and addictions system that will meet the needs of Ontarians. The Government is focused on building accountability into

its work, including public reporting, to measure the impact of new investments. As a start, the ICES and Health Quality Ontario will engage in public reporting of hospital-based performance measures and wait time data related to the mental health and addictions system.

## Patients Who No Longer Need Psychiatric Hospital Care Cannot Be Discharged

### Recommendation 2

*In order to ensure that wait times are reduced and that health care dollars are spent in the most efficient way, the Ministry of Health and Long-Term Care, together with Local Health Integration Networks, should identify the causes and address the shortage of supportive housing and long-term-care home beds available for patients that cannot be discharged from specialty psychiatric hospitals.*

**Status: In the process of being implemented by the end of March 2019.**

### Details

Our 2016 audit found that about one in 10 beds in specialty psychiatric hospitals was occupied by patients who no longer needed to be treated in the hospital but could not be discharged due to the lack of beds in supportive housing or at long-term-care homes.

During our follow-up, the Ministry and the LHINs confirmed that a lack of supportive housing has prevented patients from being discharged from hospitals. The Ministry and LHINs have taken actions to address this issue. For example:

- In February 2017, the Ministry announced new funding to create up to 1,150 supportive housing units for people living with mental illness and addictions over two years (from 2017/18 to 2018/19).
- The Ministry has invested \$8.5 million in 2017/18 and is exploring how to continue supporting various programs (such as Safebed, Mental Health Court Support

Workers, and Release from Custody Workers) that are targeted at mental health patients involved in the justice system. These programs are intended to divert these patients from being incarcerated or admitted unnecessarily to hospitals, which may free up some long-term in-patient psychiatry beds for those who need them.

- The Champlain LHIN has worked with the City of Ottawa and supportive housing providers to create new housing spaces. Subsequent to our 2016 audit, the number of rent supplement units has increased by 78 units, and an additional seven full-time supportive-housing case managers and workers have been hired.
- The Toronto Central LHIN, in partnership with the supportive housing providers, has funded 68 new rent supplement units and 8.5 new case managers in 2017/18. The LHIN has submitted a plan to the Ministry to introduce another 72 rent supplement units and nine case managers in 2018/19.
- The North Simcoe Muskoka LHIN, working with the Ministry and regional partners, has developed a two-year initiative to support individuals with mental illness. In 2017/18, the LHIN allocated \$378,000 to fund 36 new supportive housing units and an additional 4.5 mental health case manager positions. In 2018/19, the LHIN will allocate an additional \$210,000 to support 20 more rent supplement units and 2.5 more case manager positions.
- The Ministry approved additional funding in January 2018 for the Central East LHIN to support 96 additional rent supplement units and 12 new intensive case management positions. Additionally, the Ministry indicated that it plans to collaborate with other ministries to address shortages in supportive housing.

## Long-Term Psychiatric Beds Closed across Province

### Recommendation 3

*In order to improve access for Ontarians to the mental health services they need as close to their own communities as possible, the Ministry of Health and Long-Term Care and Local Health Integration Networks (LHINs) should:*

- *determine the number of long-term psychiatric beds needed in each region of the province to meet the demand by Ontarians for these mental health services;*

**Status: Little or no progress.**

### Details

Our 2016 audit found that between 2011/12 and 2015/16, there was a net reduction of 134 long-term psychiatric beds across the province. Thirty-two of the long-term beds that were closed were at specialty psychiatric hospitals.

During our follow-up, we noted that the Ministry has not determined the number of long-term psychiatric beds needed in each region of the province to meet the demand by Ontarians for these mental health services.

As mentioned in **Recommendation 1**, the Ministry informed us that in July 2018, it was committed to investing \$1.9 billion to match the federal government's contribution, for a total of \$3.8 billion over the next 10 years to build a comprehensive mental health and addictions system that will meet the needs of Ontarians.

The Ministry informed us that it will continue to work with the LHINs and hospitals to determine their long-term psychiatric bed requirements as part of their regional planning and capacity analysis. The Ministry aims to achieve this through the commitment to invest \$1.9 billion over the next 10 years to build a comprehensive mental health and addictions system and the commitment to end hallway health care. For example, in the Toronto Central LHIN, CAMH has undergone a master planning process to determine ongoing needs for its

long-term psychiatric patients. The North Simcoe Muskoka LHIN has engaged Waypoint in capacity planning to determine the number of long-term psychiatric beds needed, and has begun using the Provincial Inpatient Mental Health Bed Registry to monitor long-term psychiatric bed occupancy.

Additionally, the Ministry is committed to working across government to address shortages in supportive housing. This could assist in reducing the demand for long-term psychiatric beds in hospitals.

- *set a target for the number of long-term psychiatric beds needed in each LHIN, monitor it regularly to ensure it is being achieved;*

**Status: Little or no progress.**

#### Details

Our 2016 audit found that a report in 1988 recommended all residents of Ontario have access to mental health services in or as close to their own communities as possible. Due to the absence of target levels of service across the province, almost 30 years later this was still not the case for sufferers of the most complex and severe forms of mental illness.

During our follow-up, the Ministry informed us that it will continue to work with the LHINs and hospitals to determine their long-term psychiatric bed requirements through regional planning and capacity analysis, as part of its commitment to invest \$1.9 billion over the next 10 years to build a comprehensive mental health and addictions system and end hallway health care, as mentioned in the previous action item.

- *publicly report this information.*

**Status: Little or no progress.**

#### Details

At the time of our follow-up, the Ministry informed us that there has been no public reporting on the target and the number of long-term psychiatric beds needed in each region of the province to meet the demand by Ontarians for these mental health services, because the guidelines for public report-

ing had not yet been developed. As mentioned in **Recommendation 1**, the Government is focused on building accountability into its work, including public reporting, to measure the impact of new investments. As a start, the ICES and Health Quality Ontario will engage in public reporting of hospital-based performance measures and wait time data related to the mental health and addictions system.

In addition, the LHINs informed us that they will work with the Ministry on standard public reporting. For example, the Champlain LHIN will determine appropriate indicators, including the number of beds and wait times by program and diagnosis, after its review of hospital performance in spring 2019. It intends to publicly report this information at that time.

## Ineffective Funding Results in Patient Needs Not Being Met

### Recommendation 4

*In order to deal with the growing wait times for specialty psychiatric hospital service, the Ministry of Health and Long-Term Care and Local Health Integration Networks should as soon as possible address those wait times that are long, as well as develop an overall strategy to reduce wait times, by:*

- *setting wait time targets for specialty psychiatric hospital services;*

**Status: In the process of being implemented by December 2018.**

#### Details

Our 2016 audit found that specialty psychiatric hospitals' accountability agreements with their respective LHINs were not based on any targets related to reducing wait times or improving the quality of care received by hospital patients.

As mentioned under the first action of **Recommendation 1**, the Ministry, in partnership with the specialty psychiatric hospitals, has worked on the Access to Care initiative, which aims to use hospital data to track specific wait times and

identify service gaps. The Ministry will endorse and adopt wait time indicators and targets through the Access to Care initiative. The Ministry expects that the Access to Care initiative will be completed by December 2018.

- *collecting relevant information, such as the number of long-term psychiatric beds that exist for each mental illness diagnosis and wait times, from specialty psychiatric hospitals to determine where additional funding should be allocated;*  
**Status: Little or no progress.**

#### Details

Our 2016 audit found that neither the Ministry nor the LHINs collected information from specialty psychiatric hospitals on what programs they offered, analyzed how many patients of each mental illness diagnosis they treated, or collected information on how long patients had to wait to be admitted to a hospital or an out-patient program.

During our follow-up, we noted that the Ministry had not collected from specialty psychiatric hospitals relevant information, such as the number of long-term psychiatric beds that exist for each mental illness diagnosis and wait times, to determine where additional funding should be allocated. The Ministry indicated that information relating to the Forensic Mental Health programs had been collected. For example, the Hospital Service Accountability Agreement requires specialty psychiatric hospitals to report on the number of forensic beds they have each year; wait times for court-ordered forensic assessments are monitored by the Ministry of Community Safety and Correctional Services; and inter-hospital transfer wait lists and wait times are monitored by the Ontario Review Board.

The Ministry indicated that it plans to use its data collection and performance measurement work on wait time definitions to assess health service use and quality. As mentioned in **Recommendation 3**, the Ministry will also continue to work with the LHINs and hospitals to determine their

long-term psychiatric bed requirements as part of regional planning and capacity analysis.

- *consider tying funding for specialty psychiatric hospitals' ongoing operations to the volume of service that they provide so that they can meet wait time targets.*

**Status: Little or no progress.**

#### Details

Our 2016 audit found that for 2016/17, the Ministry provided each specialty psychiatric hospital with a 2% increase in funding for its ongoing operations. However, this funding increase was primarily based on population growth and the change in inflation rate and not on actual demand for hospital services.

In order to ensure the delivery of high quality health services and shorter wait times, the Ministry indicated that it will work with the LHINs to make needs-based planning and funding decisions through the government's commitment to invest \$1.9 billion over the next 10 years to build a comprehensive mental health and addictions system.

## Spending on Direct Patient Care below Comparator Hospitals

### Recommendation 5

*In order to ensure that Ministry of Health and Long-Term Care funding is focused on direct patient care, specialty psychiatric hospitals should identify ways to shift more spending to patient care compared to non-patient care expenses.*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that since 2011/12, spending by specialty psychiatric hospitals on direct patient care decreased by 2 cents, from 64 cents to 62 cents in 2015/16, out of every dollar spent. The remaining 38 cents were spent on non-direct patient expenses such as salaries for management, supplies and information systems.

During our follow-up, the hospitals indicated that a significant portion of their non-patient care



expenses or administrative costs are fixed costs (such as facilities and IT systems) and that reducing such costs will be an ongoing part of their annual planning as they seek to reduce costs and improve efficiency. We noted that the hospitals have taken actions to reduce administration costs in a number of non-clinical areas through improving their operational efficiencies, and to direct more funding toward clinical care for patients. For example:

- CAMH examined opportunities and was able to reduce its administration cost by \$1.1 million (from areas such as finance, legal, communications and information technology) in its operating plan for 2018/19.
- Ontario Shores has undertaken annual reviews of operational efficiencies to balance its budget and achieved savings of about \$600,000 in indirect care costs (mainly in general and program administration areas) in its 2018/19 budget.
- Waypoint examined opportunities and was able to reduce its overhead costs (from areas such as senior administration and house-keeping) by almost \$800,000 over two years (2017/18 and 2018/19).
- The Royal reviewed its operations from an efficiency perspective (such as group purchasing and centralizing administration staff) and was able to reduce its administration costs by about \$1.7 million in areas such as finance, information systems, supply chain and human resources.

## Differences in How Specialty Psychiatric Hospitals Provide Care

### Recommendation 6

*To create consistency in the delivery of mental health services across the province, the Ministry of Health and Long-Term Care should set a timetable for the development of mental health standards. These standards should include:*

- *clear definitions and guidelines specialty psychiatric hospitals should be required to follow in terms of which patients they admit to their hospitals (such as requiring hospitals to use the Level of Care Utilization System at admission);*  
**Status: Little or no progress.**

### Details

Our 2016 audit found that, although other jurisdictions (such as Nova Scotia and the United Kingdom) had mental health standards at specialty psychiatric hospitals, such standards did not exist in Ontario and there was no timetable set to create them.

During our follow-up, we found that Health Quality Ontario (HQP), which is the agency that advises the Ministry and health-care providers on the evidence to support high-quality care, has developed a number of quality standards related to the provision of care for individuals with mental health and addiction-related diagnoses. Mental health and addiction-related quality standards that have been completed include major depression, schizophrenia, behavioural symptoms of dementia, opioid use disorder, opioid prescribing for chronic pain, and opioid prescribing for acute pain. Mental health and addiction-related quality standards under development include anxiety disorders, obsessive compulsive disorder, and alcohol use disorder. HQP has also developed Recommendations for Adoption (or Implementation Plans) for each quality standard. HQP has communicated the quality standards and recommendations to the Ministry and health-care service providers.

However, we found that the quality standards do not specify admission criteria for specialty psychiatric hospitals to follow. The Ministry informed us that the goal of the quality standards is to provide broadly applicable guidance around high-quality, evidence-based and inter-professional care for mental health patients across multiple settings, including but not limited to, in-patient care. They are intended to be used as a basis for quality improvement, but are not mandatory

requirements intended to specify definitive clinical practices in any one particular setting. Therefore, the quality standards are not developed explicitly for specialty psychiatric hospitals and do not specify admission criteria.

The Ministry further indicated that admission is based on clinical decisions made by physicians. Hospitals have developed their own clinical pathways and practice guidelines to help standardize care and improve quality in their organizations. Regulatory colleges and other professional organizations also provide guidelines or best practice for clinical practice. Admission conditions are outlined by the *Public Hospital Act* and *Mental Health Act*. According to the Ministry, physicians control admission based upon their clinical expertise, and the Ministry has delegated the control of regulated health professionals, including physicians, to the professional colleges under the *Regulated Health Professions Act*.

Additionally, the Ministry informed us that the Forensic Directors Group of Ontario (formed by the specialty psychiatric hospitals and designated forensic psychiatric hospitals) has created a document on admissions principles, which sets out principles for the forensic programs to follow when addressing wait list issues and admissions of court-ordered assessment clients. Adherence to these principles is not monitored by the Ministry, as issues are identified by the hospital or through the court system.

- *how similar patients should be treated;*

**Status: Little or no progress.**

#### Details

Our 2016 audit found that mental health standards improved consistency in the care that people with the same diagnosis received across different hospitals. However, these standards did not exist in Ontario.

As previously mentioned, HQO has developed mental health-related quality standards. However, the Ministry informed us that the goal of the quality standards is to provide broadly applicable

guidance around high-quality, evidence-based and inter-professional care for mental health patients across multiple settings, including but not limited to, in-patient care. They are intended to be used as guidelines to enable quality improvement, but are not mandatory requirements intended to specify definitive clinical practices in any one particular setting. The Ministry further indicated that treatment is based on clinical decisions made by physicians. Hospitals have developed their own clinical pathways and practice guidelines to help standardize care and improve quality in their organizations. Regulatory colleges and other professional organizations also provide guidelines or best practice for clinical practice. Additionally, the Ministry indicated that treatment of forensic clients is also determined by the Ontario Review Board (Board), which has jurisdiction over individuals who have been found by a court to be either unfit to stand trial or not criminally responsible on account of mental disorder. The Board's dispositions provide standards and guidelines around delivery of care and information concerning the clients' hospital, facility, and/or doctor.

- *how and when they should be discharged from the hospital.*

**Status: Little or no progress.**

#### Details

Our 2016 audit found that each specialty psychiatric hospital developed its own standards pertaining to patient discharge. These standards sometimes varied between hospitals.

As previously mentioned, HQO has developed quality standards, which include statements associated with patient discharge from the hospitals. For example, adults with a primary diagnosis of schizophrenia discharged from an in-patient setting should have a follow-up appointment within seven days and should have a team or provider, who is accountable for communication, co-ordination and delivery of a care plan that is tailored to each patient's needs.

While HQO's quality standards, which are not mandatory, include statements associated with best practices following a patient's discharge from hospitals, they do not include specific statements related to how and when patients should be discharged. The Ministry indicated that discharge is based on clinical decisions made by physicians. Hospitals have developed their own clinical pathways and practice guidelines to help standardize care and improve quality in their organizations. Regulatory colleges and other professional organizations also provide guidelines or best practice for clinical practice. Discharge conditions are outlined by the *Public Hospitals Act* and *Mental Health Act*. According to the Ministry, physicians control discharge based upon their clinical expertise, and the Ministry has delegated the control of regulated health professionals, including physicians, to the professional colleges under the *Regulated Health Professions Act*. Additionally, the Ministry indicated that discharge of forensic clients is also determined by the Ontario Review Board as mentioned above. The Board's dispositions provide information concerning the clients' hospital, facility and/or doctor that the individuals must remain connected to. The dispositions also detail what level of security (maximum, medium or minimum) the individuals will be placed in.

### Recommendation 7

*To ensure that all of a patient's treatment needs are identified and documented, specialty psychiatric hospitals should:*

- *train staff on the need for admission assessments to be completed for all patients;*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that when admitting patients, staff at each specialty psychiatric hospital were required to perform a number of assessments to identify treatment needs. However,

many patients' files were missing some of the required assessments.

During our follow-up, we found that hospitals have taken actions to reflect best practices, such as performing literature reviews, conducting gap analyses and revising their admission assessment and documentation processes. The hospitals have also educated staff on the need for admission assessments to be completed for all patients. For example, CAMH and The Royal have implemented a new nursing workflow at all in-patient units. The nursing workflow sets out the documentation standards and procedures, as well as requirements that outline all assessments to be completed upon admission. As well, Waypoint and Ontario Shores have reviewed their admission policies to ensure alignment with best practices and educated all nursing staff on the revised patient admission assessments. They have also developed education plans that provide clinical staff, managers and clinical nurse specialists with details on what should be undertaken to support the implementation and adoption of practices and documentation.

- *conduct regular audits of patient files to verify staff are completing these assessments required by hospital policy and take corrective action when this is not occurring.*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that files related to admission assessment were missing at some specialty psychiatric hospitals.

During our follow-up, we noted that the hospitals conducted audits on a monthly basis in 2017 to ensure that their staff have complied with hospital policies related to admission, such as completing the Psychosocial Assessment within 21 days of admission; completing the Nursing Mental Health History Assessment within 72 hours of admission; using the Admission Order Set on admission; and updating the Plan of Care monthly. The hospitals reported and addressed any deficiencies found

during the audits, then contacted staff and clinical managers monthly to remedy any gaps identified.

The hospitals have also undertaken monitoring activities to ensure that their staff followed policies. For example, CAMH has required that its physician records be routinely audited by the office of its Psychiatrist-in-Chief, and The Royal has plans to replace its manual audit process with an automated process after it implements the next iteration of the electronic health records in June 2019.

### Recommendation 8

*In order for patients to be given the highest quality of care, specialty psychiatric hospitals should:*

- *review their care planning policies to confirm they incorporate best practices for patient care planning;*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that each specialty psychiatric hospital was required to do a mandatory assessment of patients during admission in order to identify key health and behavioural risks. We found cases where hospitals did not document all significant risks and needs identified in the patient's care plan.

During our follow-up, we noted that the hospitals have participated in reviews and activities to ensure that they have incorporated best practices for patient care planning. Key activities completed include conducting literature reviews of best practices in care planning; reviewing policies to ensure alignment with findings from literature reviews; drafting and sharing care policies among hospitals; and reviewing care planning expectations and documents.

- *perform an analysis to determine why staff are not following the hospital's patient care plan and discharge planning policies;*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that the requirements for care planning at each specialty psychiatric hospital differed and many care plans were completed late or missing required information.

During our follow-up, we found that hospitals have performed analyses to determine why staff did not follow patient care plan and discharge planning policies. Specifically:

- Waypoint and Ontario Shores conducted gap analyses in relation to care planning and discharge practices, and made changes such as improving documentation and workflow, implementing standardized care plans, as well as reviewing plan of care reports monthly.
- The Royal launched a quality improvement initiative to determine and analyze factors that influence compliance with care planning expectations.
- CAMH conducted audits to review completion rates of patient care plans in order to determine if and why staff were not following the requirements.

- *require staff to determine appropriate programs and activities that will help with each patient's treatment and incorporate these into each patient's care plan. Develop methods to encourage patients to participate in these identified activities;*

**Status: Fully implemented.**

#### Details

Our 2016 audit found cases where patients' care plans did not usually include any clear goals for the type or amount of activities and programs that patients should participate in.

During our follow-up, we noted that specialty psychiatric hospitals have required staff to determine appropriate programs and activities that will help with each patient's treatment and incorporate these into each patient's care plan. The hospitals have also required staff to monitor the completion

rate of care plans and implemented electronic documentation of care plans in order to incorporate evidence-based practices (such as clinical protocols and quality standards) and patient's recovery goals.

Specifically, The Royal has updated its care plans to ensure meaningful interventions and activities designed for patients. It has also worked with clinicians and patients to determine activities that would assist with recovery, and made changes in its staff mix to ensure the availability of activities aligned with patient needs. In addition, CAMH has engaged patients to participate in the development of care plans in order to determine care planning goals and programs based on patient needs.

- *take corrective action so that all aspects of the hospital's care planning and discharge planning policies can be completed by staff. These policies include:*
  - *adding all identified patient risks in care plans;*
  - *completing care plans on time;*
  - *including all critical information in care plans;*
  - *having regular meetings to update the care plan; and*
  - *performing discharge planning once a patient has been admitted.*

*The corrective action should be done by management in collaboration with staff to ensure that time spent completing the necessary documentation does not take away from direct patient care.*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that the goals in the patients' care plans were not updated on a regular basis. Discharge plans were also done late or not documented.

During our follow-up, we found that specialty psychiatric hospitals have taken actions to ensure that their staff have met the requirements of the

hospital's care planning and discharge planning policies. For example:

- As previously mentioned, The Royal has updated its care plans to ensure meaningful activities designed for patients.
- Waypoint and Ontario Shares have conducted regular audits of care plans and shared audit results with clinical managers to ensure corrective actions have been taken.
- Ontario Shores has included "adherence to plan of care being updated monthly" as a performance indicator on its balanced scorecard.
- Waypoint has implemented a discharge initiative, which includes distributing a discharge note (with information from the patient's medical records) to the patient's out-patient primary care provider within 48 hours after discharge and setting appointments within seven days of discharge as part of the discharge plan.
- CAMH has implemented electronic health record optimization activities to streamline documentation practices through working with physicians and staff.

#### Recommendation 9

*Specialty psychiatric hospitals should continue to develop treatment methods and establish an ongoing forum for sharing them with the other specialty psychiatric hospitals and with other general hospitals that also provide mental health services.*

**Status: Fully implemented.**

#### Details

Our 2016 audit found that there was no process for specialty psychiatric hospitals to share new treatment methods developed by their peers.

During our follow-up, we found that specialty psychiatric hospitals are now sharing information with each other with respect to mental health care. For example, as mentioned under **Recommendation 6**, HQO has developed quality standards for mental health care. The hospitals we audited in 2016 have been working together to implement the

HQO quality standards in schizophrenia, dementia and depression by developing a common and standardized reporting tool to monitor adherence at their hospitals. The hospitals have selected 15 indicators to be included in the standardized reporting tool, such as “percentage of patients with suspected severe major depression who have received a comprehensive assessment within seven days of initial contact (referral received).”

In January 2018, working groups were established and final definitions for each of the 15 indicators were approved by the steering committee. Each hospital has submitted a plan for implementing the standards and measurement of the 15 common indicators.

## Lack of Ministry Oversight and Information May Be Hindering Improved Mental Health Patient Care

### Recommendation 10

*To better understand how accessible, available and effective mental health services are provincially, including specialty psychiatric hospital services, the Ministry of Health and Long-Term Care should:*

- *perform an analysis to determine why emergency department visits for mental health treatment have increased provincially;*

**Status: In the process of being implemented by the end of March 2021.**

### Details

Our 2016 audit found that between 2011/12 and 2015/16, emergency room usage for mental health reasons increased 21%, while Ontario’s population grew by only 4%. However, the Ministry had not conducted any analysis to determine why emergency department visits for mental health reasons had increased.

As mentioned under the first action of **Recommendation 1**, through the Ministry’s Data Strategy and the Adult Mental Health Scorecard published

by the Institute for Clinical and Evaluative Sciences, indicators will be developed to enable tracking and analysis of emergency department visits for mental health and addictions. An indicator on “in-patient hospital readmissions within 30 days for mental health and/or addictions treatment” will be implemented in 2018/19. After this, the Ministry intends to perform an analysis by the end of March 2021 by using the results of this indicator and other hospital-based performance indicators to determine the reasons for the increase of emergency department visits for mental health treatment.

- *conduct a review and adopt better indicators and targets for assessing mental health, such as those used by specialty psychiatric hospitals in their Mental Health and Addictions Quality Initiative scorecard.*

**Status: In the process of being implemented by the end of March 2021.**

### Details

Our 2016 audit found that the Ministry had only two targets directly related to mental health to assess access to and availability of community services for mental health conditions and substance abuse in each LHIN.

As previously mentioned, through the Ministry’s Data Strategy and the Institute for Clinical and Evaluative Sciences’ Adult Mental Health Scorecard, work has been underway to develop mental health and addictions indicators and targets. The Ministry indicated that the Data Strategy is ongoing, with all indicators and targets to be developed, populated and implemented by the end of March 2021. The Ministry also indicated that new indicators will be developed beyond 2021 as the need arises.

## Not Enough Mental Health Emergency Departments

### Recommendation 11

To allow people with mental health and addiction issues to access the care they need as quickly as possible, the Ministry of Health and Long-Term Care should conduct a review to determine whether there is benefit in creating additional dedicated mental health emergency departments within general or specialty psychiatric hospitals. These departments would allow patients to be treated in a safe manner and be able to be transferred directly from the emergency department to long-term psychiatric beds at specialty psychiatric hospitals when needed.

**Status:** In the process of being implemented by the end of November 2019.

### Details

Our 2016 audit found that CAMH had the only emergency department in Ontario that was exclusively for those experiencing mental health issues. Despite there being benefits to having dedicated mental health emergency rooms, the Ministry had no plans to create additional ones.

At the time of our follow-up, we noted that the Ministry has developed a draft project charter with scope and work plan for a Mental Health Emergency Department Review. This review is to assess and determine the features, benefits and considerations of, and barriers and alternative solutions to, developing a dedicated mental health emergency department. The Ministry expects that the review will be completed by the end of March 2019.

## Lack of Patient Information Sharing

### Recommendation 12

To improve the way in which mental health stakeholders across the province share information, the Ministry of Health and Long-Term Care should:

- work with Local Health Integration Networks (LHINs) and set a timetable for the sharing

of information in each LHIN so that regional mental health service providers can share what services they provide to patients with each other;

**Status:** In the process of being implemented by September 2019.

### Details

Our 2016 audit found that the Ministry had not ensured that the same level of co-ordination and information sharing existed between different mental health stakeholders.

As mentioned under the first action of **Recommendation 1**, the Ministry has initiated a Data Strategy, which will integrate both addictions and mental health assessment records through the Integrated Assessment Record (IAR). The IAR will allow service providers across Ontario to share and access patients' assessment records between multiple sectors, including the LHINs, community mental health and addiction agencies, community support services, and long-term-care homes, in order to identify service overlaps and gaps. Work in progress includes adding the capacity to obtain client service utilization information and integrating community addictions assessments into the IAR. Work related to the IAR is expected to be completed by September 2019.

- work with LHINs and specialty psychiatric hospitals to develop processes for hospitals to share information across LHINs (to other mental health service providers and hospitals) for the benefit of patients and service providers;

**Status:** Fully implemented.

### Details

Our 2016 audit found that only one LHIN had a database that allowed all providers of mental health services to look up patients' information to identify all the care and services that patients were receiving.

During our follow-up, we noted that the Ministry has worked with the LHINs and hospitals to share information and practices through meetings, forums and information sharing systems, such as

the Integrated Assessment Record (IAR) as mentioned earlier, which provides a central repository for clinical assessment data collected from multiple in-patient and community care sectors. Assessments from in-patient mental health settings such as specialty psychiatric hospitals are viewable by community mental health and addictions providers, and vice versa, which strengthens the ability of providers to provide co-ordinated and informed care throughout the patient’s journey through the health system.

The LHINs have also developed processes to collect and share information. For example, in the Toronto Central LHIN, the Mental Health and Addictions Acute Care Alliance (Alliance) is a collaboration involving the Department of Psychiatry at the University of Toronto and seven hospital-based psychiatric programs funded by the LHIN. The key purpose of the Alliance is to facilitate community partnerships and knowledge sharing. As well, the Central East LHIN, North Simcoe Muskoka LHIN, and Champlain LHIN have worked with the specialty psychiatric hospitals in their regions to facilitate information sharing. The LHINs have worked together to expand a Hospital Information System, which has enabled hospitals in their regions to develop and implement best practices and clinical standards; support mental health research; enhance the use of common technology and standardized processes; and improve operational efficiency.

- *develop protocols for hospitals to share information with police to ensure police can obtain the information they need to do their job while protecting patient privacy.*

**Status:** Little or no progress.

#### Details

Our 2016 audit found that hospitals were not willing to share patient information with the police, mainly because under the *Personal Health Information Protection Act*, personal health information cannot be shared without express consent of the

patient. Without this information, the police had to assume patients posed a high risk of danger to the public, which could lead to excessive use of force.

During our follow-up, we noted that the Ministry of Health and Long-Term Care and the Ministry of Community Safety and Correctional Services have provided funding to the Provincial Human Service and Justice Coordinating Committee to develop a province-wide protocol for hospitals to share information with police. The protocol, called “Improving Police-Hospital Transitions: A Framework for Ontario”, was under development in collaboration with a variety of stakeholders including the LHINs, Ontario Hospitals Association, Ministry of the Attorney General, and policing organizations. The release date of this framework has not been determined.

## Staff Seek Improved Safety

### Recommendation 13

*To help ensure that staff feel safe while at work, specialty psychiatric hospitals should:*

- *update their policies to require management to keep staff regularly informed on what changes they are making to improve security and staff safety so that reported security incidents do not occur again;*

**Status:** Fully implemented.

#### Details

Our 2016 audit found that specialty psychiatric hospitals did not require management to communicate with their staff about what actions they took to prevent all reported safety and security incidents from occurring again.

During our follow-up, we found that the hospitals have updated their policies to require management to keep staff regularly informed on changes made to improve security and staff safety through various methods such as Joint Occupational Health and Safety Committees, Violence in the Workplace Committees, department or program



meetings, system-wide emails and intranets. The hospitals have also kept their staff informed and updated through safety education, which includes courses such as crisis prevention, emergency code training, conflict management, respect and civility training, Gentle Persuasion Approach (GPA), and PIECES—Physical, Intellectual, Emotional, Capabilities, Social.

- *continue to survey staff on their satisfaction with management's response to reported safety incidents and take corrective action when staff satisfaction remains low.*

**Status: Fully implemented.**

#### Details

During our 2016 audit, we found that almost 60% of staff who responded to staff surveys conducted at specialty psychiatric hospitals indicated that management was not taking effective action in response to reported safety incidents.

During our follow-up, we noted that the hospitals have continued to conduct staff surveys annually or bi-annually. The surveys included questions related to staff experience on health and safety issues, such as asking staff if they thought management responded in a timely manner to safety incidents and took corrective action to safety incidents. The surveys were conducted by external firms to ensure confidentiality and consistent benchmarking among hospitals. Survey results were reported to all staff as well as hospitals' boards of directors. We noted that hospitals have taken corrective actions to address issues identified by the survey. Examples of actions taken by the hospitals include adding more security officers who are dedicated to clinical services to enhance staff and patient safety; introducing mandatory crisis prevention and intervention training; upgrading equipment on some patient care units to monitor patient activity; and reviewing communication processes related to health and safety updates to staff.

#### Recommendation 14

*To help ensure that staff can feel safer in the new forensic building, the Waypoint Centre for Mental Health Care (Waypoint), in collaboration with staff, should:*

- *address all design deficiencies impacting staff and patient safety in a formal action plan with set target dates for completion of each deficiency;*

**Status: In the process of being implemented by the end of December 2018.**

#### Details

Our 2016 audit found that in May 2014, Waypoint relocated its forensic patients into a newly constructed building. In the first year after relocation, 90 deficiencies contributed to more than 470 reported safety hazards.

During our follow-up, we found that Waypoint had addressed all but two of these issues. The remaining two (noise mitigation and training for nursing staff to monitor some of the security functions) are expected to be completed by the end of December 2018.

- *communicate this plan to staff;*

**Status: In the process of being implemented by the end of December 2018.**

#### Details

Our 2016 audit found that from May 2014 to April 2016, the Ministry of Labour issued 12 compliance orders to address safety issues that occurred in the new building at Waypoint.

During our follow-up, we noted that Waypoint has regularly communicated to staff its action plan for issues related to the forensic building. For example, in March 2018, Waypoint issued a memo providing all staff with updates on the status of the two remaining issues mentioned above. Waypoint intends to continue to communicate its action plan to staff until the remaining issues are addressed by the end of December 2018.

- regularly update staff on deficiencies that have been resolved.

**Status: In the process of being implemented by the end of December 2018.**

### Details

As part of its regular communication to staff about its action plan related to issues in the forensic building, Waypoint made available to all managers its issues log so managers could share updates with staff. Any improvements to the forensic building have been communicated to staff through various sources (such as Health and Safety Co-ordinators, the redevelopment team and Vice President of Clinical Services). Memos and updates have been saved on the hospital's intranet site.

Waypoint held regular meetings with its program directors and staff until August 2017, at which point most of the issues had been addressed. Waypoint also provided formal updates on the resolution of forensic building issues at a staff information session in November 2017. The most recent update on the status of the two remaining issues was communicated to all staff through a memo issued in March 2018. Waypoint intends to continue to communicate its action plan to staff until the remaining issues are resolved by the end of December 2018.

## Staffing Not Based on the Level Needed for Best Patient Care

### Recommendation 15

*To help ensure that hospital staffing is at a level that allows for patients to receive the highest quality care, specialty psychiatric hospitals should:*

- review best-practice literature to develop guidelines, where relevant, for staff-to-patient ratios and full-time to part-time staffing compositions for all hospital programs;

**Status: Fully implemented.**

### Details

Our 2016 audit noted that the Registered Nurses' Association of Ontario (RNAO) consistently recommended that 70% of all nursing staff should be full-time. Only one of the four specialty psychiatric hospitals we audited was above this ratio, and all had fewer full-time staff as a percentage of overall staff than they did five years earlier.

During our follow-up, we noted that the hospitals had engaged an international think-tank to perform a literature review of best practices for staff-to-patient ratios. The review did not find evidence supporting prescribed staffing ratios in the mental health sector. For example, it reported that

- In 2015, the National Institute for Health and Care Excellence in the United Kingdom developed a guideline on safe staffing for nursing in in-patient mental health settings. As part of its development of the guideline, it conducted a review that did not find any evidence identifying "how minimum staffing levels or ratios may support safer nursing in in-patient mental health settings".
- In January 2018, the National Quality Board in the United Kingdom developed a resource for mental health services to inform staffing decisions. The resource set expectations in three key areas (right staff, right skills, and right place and time) but did not prescribe staffing ratios.

In the absence of evidence to support prescribed staff-to-patient ratios, the hospitals have been using evidence-based frameworks to guide staffing decisions. These include the "Staff Mix Decision-Making Framework for Quality Nursing Care" developed by the Canadian Nursing Association in 2012 and "Developing and Sustaining Safe, Effective Staffing and Workload Practices" developed by the RNAO in 2017.

- use this information when making hospital program staffing decisions.

**Status: Fully implemented.**

### Details

Our 2016 audit found that specialty psychiatric hospitals did not have target staff-to-patient ratios, making it unclear if existing staffing levels were appropriate.

During our follow-up, we found that the hospitals have assessed staff-to-patient ratios and staffing mix to meet their operational needs. As previously mentioned, in the absence of evidence from literature reviews to support prescribed staff-to-patient ratios, the hospitals have been using evidence-based frameworks to guide staffing decisions. In addition, when the hospitals completed their annual operating plans and assessment of other special project initiatives, they also reviewed opportunities to optimize staff skill mix and utilization.