

Specialty Psychiatric Hospital Services

1.0 Summary

There are about 2,760 long-term psychiatric beds in 35 facilities (primarily hospitals) across Ontario. 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, which are:

- 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 2015/16, these four specialty psychiatric hospitals treated about 7,200 patients and handled about 280,000 visits from out-patients (people who can manage their mental illness without needing to stay overnight at a hospital).

A referral is generally required for a person to be admitted to a specialty psychiatric hospital. Most patients are referred by general hospitals, family doctors, psychiatrists, or mental health community organizations.

When patients are ready to be discharged from a specialty psychiatric hospital but are not able to return home, or do not have a home to return to, the hospitals must co-ordinate with other care providers, such as supportive housing and long-term-care homes, to ensure that the patient's care needs will continue to be met.

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 2015/16, specialty psychiatric hospitals received \$673 million, which represents over 20% of the \$3.3 billion the Ministry spent in total on mental health care.

Our audit found that for the past five years, specialty psychiatric hospital funding did not keep up with inflation or the increased demand for mental health services. To deal with this, these

hospitals have had to close beds, which has resulted in patients now waiting longer to access specialty psychiatric hospital services.

These hospitals have also changed their employee mix to include more part-time staff. It is not clear that current resources, including staffing, allow enough activities like group therapy, or therapy involving the use of facilities available at the hospitals (such as swimming pools) to occur. These are important to a patient's treatment and patients feel there are not enough of them.

Specialty psychiatric hospitals have not been able to deal with safety concerns to the degree that staff have requested. We also found that important patient file documentation, such as inclusion of patient risks in patient care plans or updates on the status of a patient's treatment, was missing from patient files.

The Ministry and LHINs have focused less on specialty psychiatric hospitals compared to other areas of health care, such as general hospitals. The Ministry has not created mental health standards to ensure that specialty psychiatric hospitals are consistent regarding which patients they admit, how they treat those patients and how those patients are discharged. While the Ministry collects wait time information and funds general hospitals based on the demand for their services, it does not do this for specialty psychiatric hospitals. Specialty psychiatric hospitals have to regularly complete and submit the same template of information that LHINs collect from general hospitals, however this template contains very little information that is specific to mental health care or specialty psychiatric hospitals. It asks many details that specialty psychiatric hospitals return blank because they are unrelated to them, such as the number of MRIs and breast screenings they perform to detect cancer. As a result, the Ministry and LHINs are not collecting the appropriate type of information to know how successful specialty psychiatric hospitals are in treating their patients.

The following are some of our significant observations:

- **Wait times for patients to receive treatment are long and getting longer:** In 2015/16, children had to wait more than three months to receive help for severe eating disorders at Ontario Shores. 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, even though they required the treatment. Patients with borderline personality disorders (instability in mood and behaviour) waited about a month and a half in 2011/12 for a program at Ontario Shores. In 2015/16, they had to wait seven months. Our audit of hospital records over the past five years found evidence of two people who died by suicide while waiting for help.
- **More people could have been treated if patients were not staying in the hospitals longer than necessary as a result of a shortage of beds in supportive housing and long-term-care homes:** In the last five years, 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. In 2015/16, if the four specialty psychiatric hospitals had been able to find a place to discharge their patients as soon as required, the cost of caring for these people in supportive housing or long-term-care homes would have been \$45 million less, and the hospitals would have been able to treat about 1,400 more people.
- **There is a lack of long-term psychiatric beds in some regions:** In 1988, the Ministry commissioned a report that recommended the Ministry ensure all residents have access to mental health services in their own communities or as close to them as possible. Almost 30 years later that is still not the case. In the

North Simcoe Muskoka LHIN, there are no beds for children with mental illnesses. Beds dedicated for individuals with addictions are 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.

- **Long-term psychiatric beds have closed across the province:** 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. Bed reductions stemmed from the limited increase in funding specialty psychiatric hospitals got for their ongoing operations.
- **The Ministry and LHINs are not collecting relevant information for funding decisions:** 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 need (wait lists) for treatment. Without mental health targets and relevant information, the Ministry or LHINs cannot make effective funding decisions.
- **Some patient files are being completed late and are missing required information, which could impact the patient's care:** Patient files we reviewed at CAMH and Ontario Shores were updated late or missing important information. During a patient's admission, key patient health and behavioural risks are identified. These risks should be documented in a patient's care plan. Some care plans we reviewed were missing this information. About 40% of the care plans were prepared late and were missing timelines for patients' treatment goals. We also found that hospital discharge plans were completed later than they should have been, which could increase wait times for beds.
- **The hospitals are increasing their use of part-time staff:** Over the past five years hospitals shifted toward hiring more part-time staff. The Registered Nurses Association of Ontario (RNAO) recommends that 70% of all nursing staff should be full-time to achieve best quality care results. In 2011/12, three specialty psychiatric hospitals employed at least 70% of their staff who provide direct patient care on a full-time basis. Five years later, one of the hospitals had a full-time staff level above 70% and all had fewer full-time staff overall. The mix of full-time and part-time staff varies between the hospitals, and none have a target for this mix.
- **The hospitals are spending less money on direct patient care than other comparator hospitals and their spending has decreased:** Since 2011/12 specialty psychiatric hospitals' spending on direct patient care has decreased by 2 cents, from 64 cents to 62 cents in 2015/16, out of every dollar that they receive from the Ministry. This is 5% less (3 cents) than the average of 65 cents that other comparator hospitals in Ontario spend on direct patient care. During this time period, specialty psychiatric hospitals had to deal with increasing costs without much additional funding from the Ministry for their ongoing operations.
- **There are not enough mental health emergency departments in the province:** CAMH has the only emergency department in Ontario that is exclusively for people experiencing mental health issues. This emergency department was first established in the 1960s. Although Ontario's population has doubled since then, no additional mental health emergency departments currently exist in the province. The Ministry has no plans to create additional ones.
- **Waypoint's new forensic building has had deficiencies since it opened in 2014 that have seriously impacted the safety of patients and staff:** In 2014, Waypoint opened

a new building to house its high-security forensic program. Since then, 90 deficiencies impacting staff and patient safety were identified. These deficiencies, including a poorly constructed fence and a broken electronic door-closing mechanism, contributed to over 800 reported safety hazards between 2014/15 and 2015/16 (related to staff assaults, property damage, vandalism and a patient climbing over a fence to leave without authorization). 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.

- **Without provincial mental health standards, the hospitals have each created their own standards for admission, treatment and discharge, resulting in patients being treated differently:** Ontario does not have provincial mental health standards and currently there is no set timetable to create them. In Ontario, each of the four specialty psychiatric hospitals develops their own standards pertaining to patient admission, treatment and discharge. These standards can sometimes differ resulting in differences of how patients with the same diagnosis are regarded by each hospital. One general hospital reported to us that it referred the same patient to two of the specialty psychiatric hospitals, and the patient met admission standards at one hospital, but was rejected at the other.
- **Specialty psychiatric hospitals have developed new treatment methods that show improved patient care outcomes:** Specialty psychiatric hospitals are implementing new treatment methods to better treat certain mental illnesses. For instance, Ontario Shores developed a new approach to treat certain schizophrenia patients that led to a decrease in the number of patients who were prescribed multiple anti-psychotic medications.

Such medications have strong side effects. However, we found that there is no process for hospitals to share new treatment methods developed by their peers.

- **The Ministry has not done any analysis to learn why general hospital emergency room visits in Ontario related to mental health are increasing:** In the past five years, there has been a 21% increase in general hospital emergency department visits by people with mental illness. During that time, the percentage of repeat emergency visits within 30 days for substance abuse grew by 18% and for mental health by 9%. The Ministry has not conducted any analysis to determine why emergency department visits for mental health or substance abuse have increased.
- **Mental health information is not shared among the LHINs or with the police:** Only one LHIN has a database whereby all providers of mental health services can look up patients' information to identify all the care and services that patients are receiving. This ensures patients receive the care that they require and prevents duplication of care. A similar problem exists with the sharing of patients' information with the police. Police told us that some hospitals are not willing to share patient information. Without this information, the police have to assume patients who leave without authorization from specialty psychiatric hospitals pose a high risk of danger to the public, which can lead to a greater use of force.

This report contains 15 recommendations with 34 action items. It is the third in a series of three audit reports related to mental health care. The first report examines Child and Youth Mental Health, and the second examines Housing and Supportive Services for People with Mental Health Issues. For additional background information on mental health, refer to **Chapter 1**, "Introduction to Mental Health Audits."

OVERALL MINISTRY RESPONSE

The Ministry of Health and Long-Term Care (Ministry) appreciates the comprehensive audit conducted by the Auditor General and would like to take this opportunity to thank the Auditor General for providing these recommendations. The Ministry is committed to working collaboratively with its partners, making evidence-based decisions, and making improvements to sustain the health-care system in Ontario.

For over 30 years, the Ministry has focused on moving Ontarians from hospitals to the community, with appropriate supports. The Ministry is committed to funding and improving community services and supports to help Ontarians remain in their homes and communities wherever possible and prevent the need for more intensive and costly hospitalizations. The Ministry recognizes that there will be situations where an in-patient bed is required; however, in-patient stays should be as short as clinically necessary.

The Ministry is aware that additional planning and leadership are required to address mental health needs throughout the health-care sector, including the four stand-alone specialty psychiatric hospitals, six specialty psychiatric tertiary hospitals, close to 200 general hospitals with mental health beds, and more than 350 community agencies. To this end, the Ministry has established a Mental Health and Addictions Leadership Advisory Council and is working closely with the Council to strengthen system planning, accountability and integration across the mental health and addictions system. The Council, composed of representatives from diverse sectors, will provide expert advice on the implementation of the next phase of the Ministry's Mental Health and Addictions Strategy.

OVERALL RESPONSE FROM LHINs

The Local Health Integration Networks (LHINs) thank the Office of the Auditor General of Ontario and accept the observations and recommendations.

The effective delivery of high-quality mental health and addiction services is a priority for all LHINs. We will continue to work with the Ministry and health service providers to improve these services for Ontarians.

As health system planners, funders and integrators, LHINs will continue to support initiatives that create more timely access to mental health care and to create greater consistency with respect to outcomes and quality. In June 2015, the LHIN CEO Council approved the establishment of a Provincial Mental Health & Addictions (MH&A) Advisory Committee. This Committee brings together LHINs, associations, subject matter experts and other partners to share information, identify leading practices, advance priorities and develop recommendations to the LHIN CEO Council to support and inform Ontario's Mental Health and Addictions Leadership Advisory Council.

The LHINs' MH&A Advisory Committee has endorsed three pan-LHIN MH&A priorities:

- Objective 1: Ensure accessible and appropriate primary care for those experiencing MH&A conditions.
- Objective 2: Ensure better co-ordinated, centralized and integrated access points for MH&A services.
- Objective 3: Ensure availability of flexible service support housing options for key populations.

Action-oriented work groups have been formed around each of the three pan-LHIN priorities. These work groups have a mandate to develop, document and implement work plans to create change and positively impact the health and well-being of Ontarians affected by mental health and addictions issues.

OVERALL RESPONSE FROM HOSPITALS

The specialty psychiatric hospitals appreciate the comprehensive review from the Office of the Auditor General of Ontario. We share the commitment to ongoing performance evaluation, transparency and accountability to our patients, their families, staff and the communities we serve. Collaboration, implementation of best practices, care standardization and safety will continue to be key priorities for our hospitals. Each hospital has received exemplary standing from Accreditation Canada, and our joint work on the Mental Health and Addictions Quality Initiative is just one of the many examples of how our hospitals are striving for quality, collaboration and exemplary care each and every day.

We know the stigma and discrimination associated with mental illness can have as significant an impact as the illness itself. We are determined to eliminate stigma and create a society that is respectful, compassionate and supportive of those struggling with the devastating impacts of mental illness and addiction.

Our hospitals provide specialized treatment for individuals with the most serious and complex mental illnesses and addictions. Responding to delays in access to services is a priority. Often these delays are due to an increase in patient volumes, shortages of mental health professionals, and a broadening of programs and service areas with a corresponding increase in demand over time. The success of anti-stigma campaigns at the provincial and national levels is also encouraging people to seek help. We know the demand for our programs and services will continue to increase, and we are committed to working with our partners across all sectors to advance the mental health and addictions system across the continuum of care.

We have been very effective in meeting the objectives and targets as set out in our accountability agreements with our respective LHINs

and feel that additional oversight would lead to increases in administrative reporting and costs. Our mental health indicators provide us with the impetus for achieving positive clinical outcomes for our clients and serve as effective organization targets.

A number of initiatives are already underway to enhance collaboration and standardization and support continuous quality improvement efforts, including a Provincial Wait Times Strategy and implementation of Quality Standards.

We will continue to work together and with our funders to address the areas that have been identified in this report and set priorities to ensure Ontarians have access to the high-quality care they need in a safe and therapeutic setting.

2.0 Background

2.1 History and Funding of Specialty Psychiatric Hospitals

In 1993, the Ministry of Health and Long-Term Care (Ministry) published a 10-year plan for mental health service delivery in the province. At that time, about \$1.3 billion a year was being spent on mental health. About 60% of this amount went to 14 psychiatric hospitals and to other general hospitals that provided mental health care, with the remaining 40% primarily going to physicians and other community mental health service providers.

As part of its 10-year plan, the Ministry wanted to move patient care away from hospitals. To do so, it started to shift funding away from hospitals to less costly community-based care providers, such as the Canadian Mental Health Association. These providers deliver mental health care to individuals who typically continue to live in the community.

The Ministry also established the Health Services Restructuring Commission as part of its 10-year plan. The Commission's objective was to lead the process of hospital restructuring and to advise the

government on changes needed to improve the access, quality and cost-effectiveness of health-care services provided to Ontarians. The Commission decided that closing psychiatric hospitals or merging them with general hospitals would allow money previously allocated to them to be reallocated to community-based mental health care providers.

As a result, in the early 2000s, 10 of the existing 14 psychiatric hospitals were either closed or merged with general hospitals, leaving the four specialty psychiatric hospitals that exist today.

Figure 1 provides an overview of each of the four specialty psychiatric hospitals.

Since 1993, the Ministry's spending on mental health care has more than doubled to \$3.3 billion in 2015/16. From this amount, specialty psychiatric hospitals received about \$673 million, or more than 20% of the Ministry's total spending on mental health care. With the Ministry's shift towards community-based mental health care, less than 30% of the Ministry's total mental health care funding in 2015/16 was dedicated to providing care to mental health patients in general or specialty psychiatric hospitals.

During our audit, in April 2016, the Ministry created a dedicated mental health and addictions branch.

2.1.1 Oversight of Specialty Psychiatric Hospitals

The Ministry has overall responsibility for establishing a patient-focused, results-driven, integrated and sustainable publicly funded health system in Ontario.

The Ministry gives money to each of the 14 Local Health Integration Networks (LHINs). LHINs are responsible for using that money to plan, fund and integrate health services in their region, including mental health services. This includes about 2,760 long-term psychiatric beds located in 35 facilities (primarily in hospitals) across the province. About half (1,389) of these beds are in the four specialty psychiatric hospitals.

Each of the specialty psychiatric hospitals has an accountability agreement with its respective LHIN: Toronto Central (CAMH), Central East (Ontario Shores), Champlain (The Royal) and North Simcoe Muskoka (Waypoint).

These agreements identify the funding that the LHINs will provide to specialty psychiatric hospitals and the number of patients these hospitals are expected to treat. As part of the agreement, each quarter specialty psychiatric hospitals must report financial and operational information (such as the volume of patients that they treat) to their LHIN.

Figure 1: Specialty Psychiatric Hospital 2015/16 Overview

Source of data: Specialty Psychiatric Hospitals

	Centre for Addiction and Mental Health (CAMH)	Ontario Shores Centre for Mental Health Sciences (Ontario Shores)	The Royal Ottawa Health Group (The Royal)	Waypoint Centre for Mental Health Care (Waypoint)	Total
Location	Toronto	Whitby	Ottawa & Brockville	Penetanguishene	
Long-Term Psychiatric Beds as of March 31, 2016 ¹	493	326	269 ²	301	1,389
Number of Staff ³	2,141	1,054	883	997	5,075
Patient Discharges	4,470	645	1,223	904	7,242
Out-Patient Visits	96,421	65,937	97,647	19,193	279,198

1. In this report, any mental health bed not for the purpose of providing short-term mental health care located at a general hospital is considered a long-term psychiatric bed (including beds at specialty psychiatric hospitals, dedicated children's mental health beds and beds for patients whom the courts refer to hospitals for the assessment or treatment of a mental illness).
2. The Royal also has 100 beds that are used to house sentenced provincial offenders who are in need of mental health care. These are not long-term psychiatric beds and have been excluded from this total.
3. Number of staff refers to full-time equivalents reported to the Ministry.

Specialty psychiatric hospitals are public hospitals that fall under the *Public Hospitals Act*. The Act requires them to establish their own board of directors to oversee their operations.

2.2 Overview

2.2.1 Reasons for Admission to Specialty Psychiatric Hospitals

There are a number of different ways someone can be admitted to a specialty psychiatric hospital. A referral is generally required. Most patients are referred from general hospitals that do not offer the same level of specialized care as specialty psychiatric hospitals. Other patients are referred by their family doctors, psychiatrists (doctors who specialize in mental health) or mental health community organizations that provide support to people who are experiencing mental illness while living in the community.

People with mental illness who do not seek treatment on their own but are at risk of harming themselves or others can be referred to a specialty psychiatric hospital involuntarily by a psychiatrist or their family doctor. During 2015/16, about 25% of patients admitted to specialty psychiatric hospitals were admitted involuntarily. Should patients have any concerns about how they are treated at a specialty psychiatric hospital, they have access to Ministry patient advocates located at each hospital who can offer options and/or assistance to resolve their concerns.

Another group of patients at specialty psychiatric hospitals are those referred by courts and are called forensic patients. These are patients who have, or are suspected of having, mental illness and who have been charged with a criminal offence. These patients are referred to specialty psychiatric hospitals for assessments to determine whether they are fit to stand trial, or are “not criminally responsible” for an offence, or to get treatment.

In addition to programs for patients staying in the hospital, specialty psychiatric hospitals also

offer out-patient services. Out-patient services are for individuals who can manage their mental illness without needing to stay overnight at a hospital. Examples of out-patient services include a visit with a psychiatrist to ensure prescribed medication is working, or group therapy. During 2015/16, the four hospitals had about 280,000 visits from out-patients.

2.2.2 Discharge from Specialty Psychiatric Hospitals

Specialty psychiatric hospitals and other mental health service providers work together to ensure that patients’ needs are being taken care of in the most appropriate location.

When a patient is ready to be discharged from a specialty psychiatric hospital, the patient might not be able to return to their home or do not have a home to return to. For example, a senior might need the services of a long-term-care home, or an individual might require supportive housing because their mental illness is no longer something they can cope with on their own.

Specialty psychiatric hospitals must identify and co-ordinate with other service providers, such as supportive housing and long-term-care homes, to ensure that the patient’s care needs will continue to be met upon their discharge from the hospital. If this is not planned for and co-ordinated in a timely manner, patients who are ready to be discharged from the hospital must continue to stay in the hospital until appropriate community service providers are found. **Figure 2** shows an overview of the way patients enter and leave specialty psychiatric hospitals.

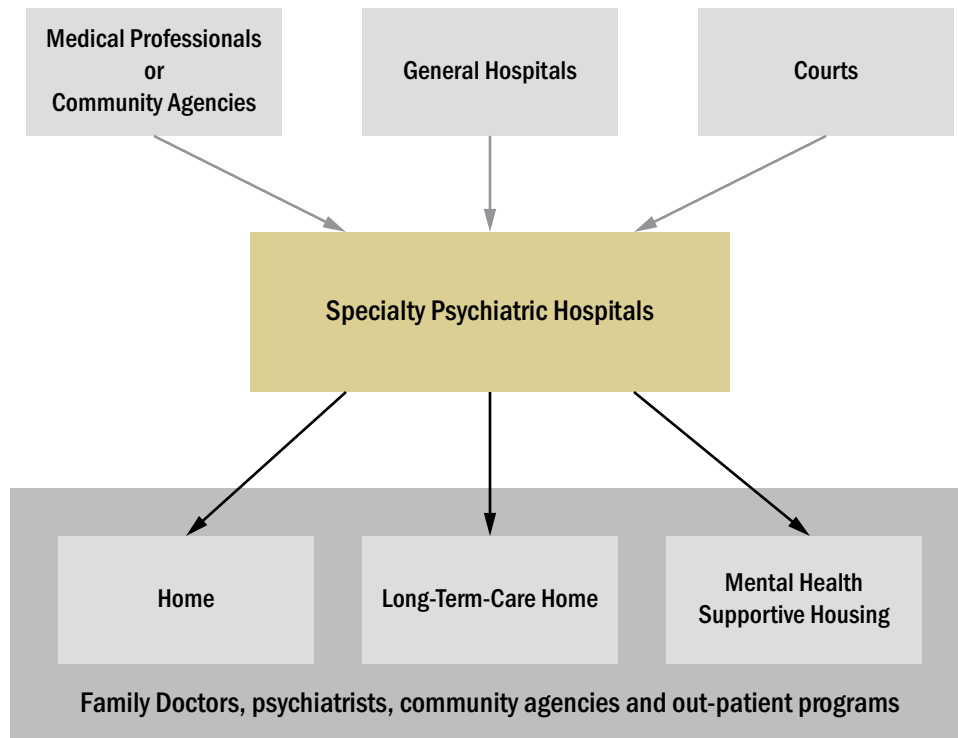
2.2.3 Types of Mental Illnesses Treated

Specialty psychiatric hospitals offer a broad range of mental health programs and treatments for various diagnoses and patient age groups.

The most common diagnoses treated include:

Figure 2: Common Ways People Enter and Leave Specialty Psychiatric Hospitals

Source of data: Specialty Psychiatric Hospitals



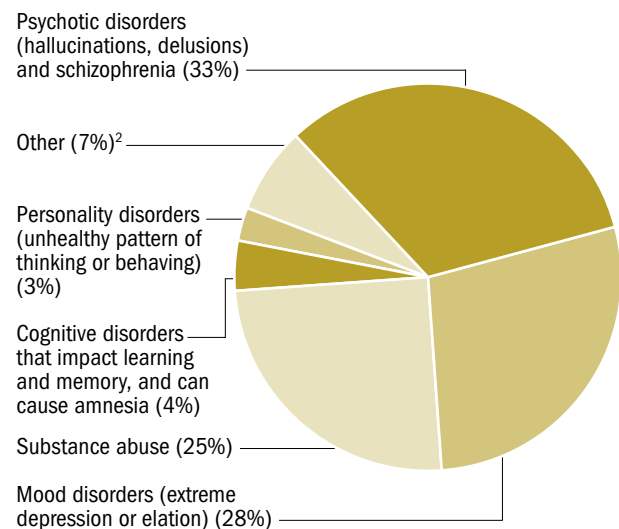
- psychotic disorders (symptoms include hallucinations, delusions and disordered forms of thinking);
- mood disorders (such as severe depression); and
- substance abuse.

The proportion of patients with these mental illnesses has remained constant between 2011/12 and 2015/16. **Figure 3** shows which mental illnesses were treated at specialty psychiatric hospitals between 2011/12 and 2015/16.

About 60% of specialty psychiatric hospital patients identified as male and 40% identified as female. This ratio was constant between 2011/12 and 2015/16. Similarly, these patients were primarily between the ages of 19 to 44. **Figure 4** shows the age of patients treated at specialty psychiatric hospitals.

Figure 3: Diagnosed Mental Illnesses of Specialty Psychiatric Hospital Patients¹

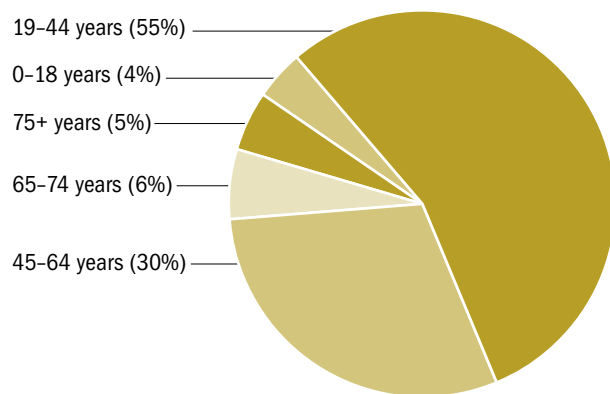
Source of data: Ministry of Health and Long-Term Care



1. Percentages represent the average between 2011/12 and 2015/16.
2. Other includes anxiety disorders (chronic and persistent feelings of apprehension), adjustment disorders (abnormal or excessive reaction to life stressors) and childhood disorders (a collection of various disorders that generally appear during childhood or adolescence related to inabilities to stay focused, communicate effectively or learn).

Figure 4: Age of Specialty Psychiatric Hospital Patients, 2011/12–2015/16

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



2.2.4 Patient Categories and Programs

Four Patient Categories

There are four categories of patients who are admitted into specialty psychiatric hospitals:

- forensic patients (who are referred by courts);
- adults (aged 18 to 64);
- seniors (aged 65 and older); and
- youth (aged 12 to 17).

Hospitals have separate beds for each patient type. **Figure 5** shows the number of beds by specialty psychiatric hospital for each patient type.

Each Specialty Psychiatric Hospital Has Unique Programs

While each specialty psychiatric hospital offers similar programs, each individual hospital also offers its own unique specialty programs. The main unique specialty programs include:

- CAMH operates Ontario's only mental health emergency department;
- Ontario Shores offers treatment for children and youth with the most severe forms of eating disorders;
- The Royal has a crisis unit for its out-patients who require urgent care; and
- Waypoint has a high-security forensic unit for individuals deemed to be at the highest risk of violence to themselves or others.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health and Long-Term Care (Ministry), Local Health Integration Networks (LHINs) and specialty psychiatric hospitals had effective policies, procedures and processes in place to ensure that specialty psychiatric hospitals are providing mental health services that meet the needs of patients and the community in accordance with legislative responsibilities. We also assessed whether specialty psychiatric hospitals are effectively integrated into the Ontario health care system, resources are efficiently used and specialty psychiatric hospital effectiveness is measured, assessed and publicly reported on.

Senior management at the Ministry, LHINs and the specialty psychiatric hospitals reviewed and agreed with our objective and associated criteria.

In conducting our work, we met with key personnel at the Ministry and visited the four LHINs where specialty psychiatric hospitals are located (Central East, Champlain, North Simcoe Muskoka and Toronto Central) where we spoke with staff involved in the oversight of specialty psychiatric hospitals and reviewed related documentation and data.

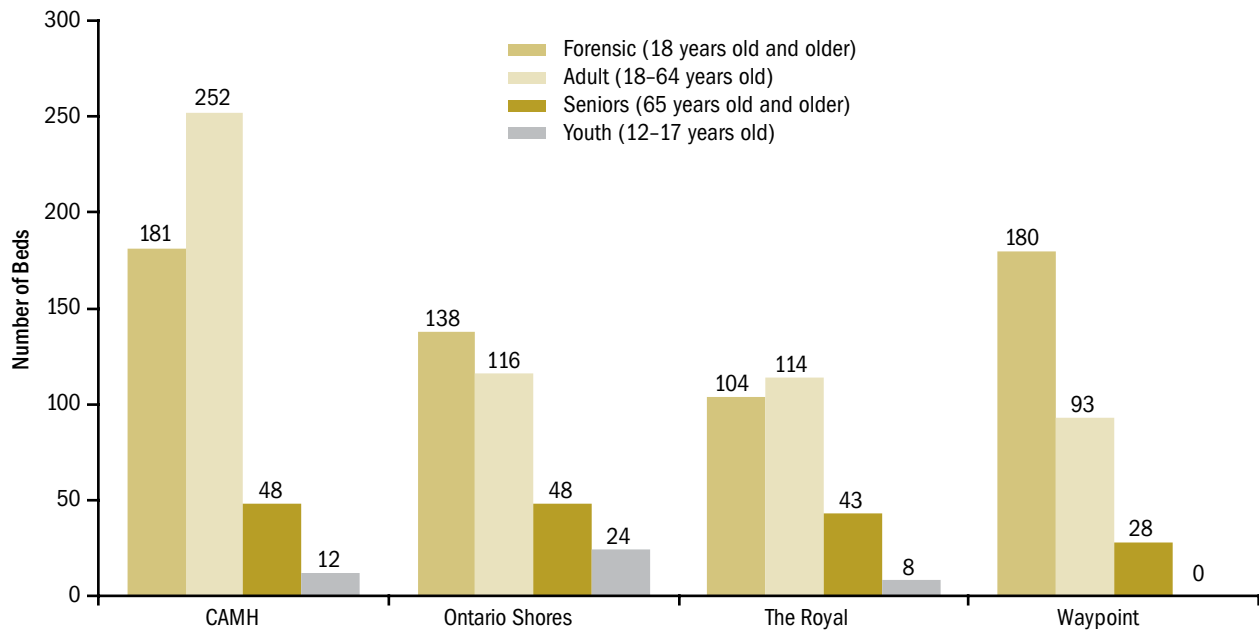
We also visited each of the four specialty psychiatric hospitals, where we interviewed senior and front-line staff to understand each hospital's operations, and examined related data and documentation. In addition, we performed a detailed review of patient files at two of the four hospitals, Ontario Shores and CAMH.

To understand specialty psychiatric hospital patient concerns, we interviewed current and former specialty psychiatric hospital patients and met with patient advocates at each hospital who are Ministry personnel and considered independent of the hospital.

To understand specialty psychiatric hospital staff concerns, we met with representatives from the Ontario Public Service Employees Union.

Figure 5: Specialty Psychiatric Hospital Beds by Patient Type, as at March 31, 2016

Source of data: Specialty Psychiatric Hospitals



To understand the challenges and needs of people with mental illness, we spoke with key representatives from Addictions and Mental Health Ontario and five Canadian Mental Health Association branches (located in Hawkesbury, Oshawa, Ottawa, Simcoe County and Toronto).

We also spoke with key representatives from six general hospitals and five police departments (located in Barrie, the Greater Toronto Area, Midland, Orillia, Ottawa and Whitby) to gain an understanding of their interactions with specialty psychiatric hospitals.

To better understand the challenges specialty psychiatric hospitals face with discharging their patients, we spoke with two supportive housing providers and three long-term-care homes (located in Midland, Ottawa and Toronto).

We researched mental health standards used in other jurisdictions and spoke with the Nova Scotia Health Authority about mental health standards used in that province.

4.0 Detailed Audit Observations

4.1 Patients Suffering From Longer Waits

Time spent on a wait list to get into a specialty psychiatric hospital or to receive care is time when a patient with mental illness is not receiving the required specialized care. This can result in a worsening of their already severe mental illness and can increase the risk of harm the patient poses to themselves or others. It also increases the likelihood that an emergency department visit will be needed to obtain immediate care.

4.1.1 Wait Times are Long and Getting Longer

We obtained wait time information by hospital program for the past five years from three of the four specialty psychiatric hospitals (Ontario Shores, The Royal and Waypoint). CAMH does not collect

such information because the majority (70%) of its patients come through its emergency department. Instead, it measures the amount of time a person must wait in the emergency department before being admitted to a hospital bed.

As of July 31, 2016, there were a total of 159 people waiting for a bed and there were about 5,000 people waiting to enter an out-patient program at the three specialty hospitals that provided us wait time information.

We found that wait times for mental health programs offered by the three hospitals are long. For example, in 2015/16, 9 children had to wait more than three months to receive help for severe eating disorders at Ontario Shores.

Figure 6 shows the in-patient programs with the longest wait times at each hospital. In **Appendix 1** we list the wait times for the remaining in-patient programs. **Figure 7** shows the out-patient programs with the longest wait times.

Wait times are also growing. On average, patients now wait longer for beds and out-patient programs than they did five years ago at each of the three specialty psychiatric hospitals. For example, to get into a bed at Ontario Shores, patients with the same diagnosis in 2015/16 waited three weeks longer than they would have five years earlier.

Figure 8 shows the growth in wait time for beds

at each hospital and **Figure 9** shows the growth in wait time for out-patient programs.

On average, in 2015/16, patients must now also wait three hours (or about 40%) longer than five years ago in CAMH's emergency department before being admitted as an in-patient to one of its hospital beds. That is, the average wait is 10.8 hours compared to 7.8 hours five years ago.

We looked at changes in wait times between 2011/12 and 2015/16 for specific in-patient programs at each hospital and noted that, for 60% of the programs, the wait became longer. For example:

- Five years ago, patients waited approximately one week for a bed in a recovery program at The Royal that helps them develop life skills to live on their own. In 2015/16, the wait was just over three months.
- The wait for a bed in a program for people with both a mental illness and substance abuse at Waypoint doubled from one and a half months in 2011/12 to close to three months in 2015/16.

We also discovered increases in wait times for some out-patient programs. For instance:

- Those with borderline personality disorders (instability in mood and behaviour) waited about a month and a half in 2011/12 for a

Figure 6: The Top Two In-Patient Programs at Specialty Psychiatric Hospitals with the Longest Wait for Patients to be Admitted, 2015/16¹

Source of data: Specialty Psychiatric Hospitals

Specialty Psychiatric Hospital	Description of Patients Treated by Program	Days Waited for Admission ²
Ontario Shores	• Youth specialized eating disorder program	105
	• Forensic patients ³	268
Waypoint	• Substance abuse and mental illness	85
	• Forensic patients ³	48
The Royal	• Recovery program	80
	• Addictions	43

1. CAMH was not included in this chart because it does not centrally collect in-patient wait time information. This is because the majority (70%) of its in-patients come through its emergency department.

2. The hospitals measure median wait times of programs. Therefore, half of the people admitted waited longer than the days listed below.

3. Forensic patients could be awaiting admission in several places. Some may wait at another hospital; some wait in jail.

program at Ontario Shores. In 2015/16, they had to wait seven months.

- People with schizophrenia waited about a month and a half in 2011/12 to enter a program at The Royal. In 2015/16, they waited over three months.

At Waypoint, the wait list for one of their main adult out-patient programs was so long that in

2015/16, the hospital temporarily stopped adding new people to the wait list, even though they required the treatment. The hospitals' staff attributed the longer waits to higher demand for mental health services, sometimes from outside the regions where they are located, and to program changes that extend patients' length of stay.

Figure 7: The Top Two Out-Patient Programs at Specialty Psychiatric Hospitals with the Longest Wait for Patients to Obtain Treatment, 2015/16

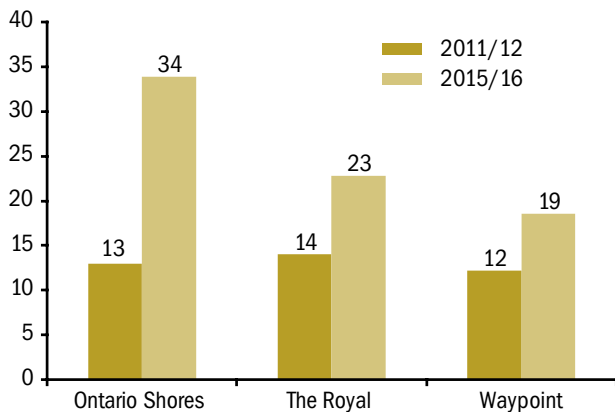
Source of data: Specialty Psychiatric Hospitals

Specialty Psychiatric Hospital	Description of Patients Treated by Program	Days Waited for Treatment*
Ontario Shores	• Borderline personality disorder	373
	• Traumatic stress	364
Waypoint	• General adult	23
	• Geriatric	29
The Royal	• Mood and anxiety	193
	• Sleep clinic	241
CAMH	• People experiencing issues with their gender identity, including those who want gender-transition surgery	141
	• Women with a history of trauma and mental illness	118

* The hospitals measure median wait times of programs. Therefore, half of the people treated waited longer than the days listed below.

Figure 8: Wait for Beds at Specialty Psychiatric Hospitals, 2011/12 and 2015/16 (Days)^{1,2}

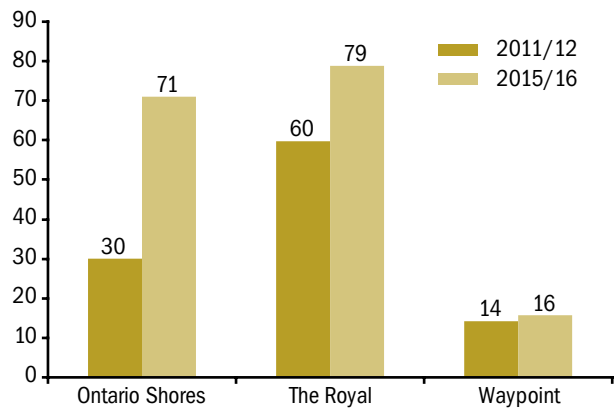
Source of data: Specialty Psychiatric Hospitals



1. CAMH is not included in this comparison because its wait times are not comparable to those of the other hospitals. CAMH tracks its wait times via the emergency department, while the other hospitals measure the wait from the time of referral to admission.
2. The hospitals measure median wait times of programs. Therefore, half of the people admitted waited longer than the days indicated below.

Figure 9: Wait for Out-Patient Programs at Specialty Psychiatric Hospitals, 2011/12 and 2015/16 (Days)^{1,2}

Source of data: Specialty Psychiatric Hospitals



1. CAMH is not included in this comparison as its central tracking of out-patient wait times was introduced only in 2014.
2. The hospitals measure median wait times of programs. Therefore, half of the people admitted waited longer than the days indicated below.

4.1.2 Wait Times Not Reported

While the Ministry collects and publicly reports wait times for a number of services offered at general hospitals, it does not do so for specialty psychiatric hospitals. This is because the Ministry has not developed a consistent way for specialty psychiatric hospitals to measure or report wait time information.

Currently, specialty psychiatric hospitals measure wait time information differently from each other. The Royal tracks it starting from the date when one of its psychiatrists determines that a patient needs treatment, whereas Ontario Shores and Waypoint start tracking wait times from the date when they receive a patient's referral. The hospitals track wait time information mostly for internal use only. Each of the specialty psychiatric hospitals publicly report wait time information for some of their programs; however, it is up to each hospital to decide what they want to report. Because the hospitals measure wait times differently, this information cannot be used to compare wait times for beds or programs among the four hospitals.

In 2014, the Ministry provided about \$2.5 million to specialty psychiatric hospitals to develop a consistent way to begin to measure wait times. This work is expected to be completed in 2017, but will only allow the hospitals to measure wait times for some of the services that they offer. Going forward, the Ministry does not have a clear plan for developing a consistent way to measure wait times for all specialty psychiatric hospital programs and to publicly report them.

4.1.3 General Hospitals Need Wait Time Information

Because the Ministry is not collecting and reporting wait times, as it does for services provided by general hospitals, neither the LHINs nor the Ministry is analyzing the exact length of time people wait on average for mental health services or, as our audit found, that wait times are growing and the impact that this is having.

We spoke with staff at general hospitals who identified that the lack of public reporting on wait times for mental health services at specialty psychiatric hospitals impacts them and their patients. General hospitals refer their patients to specialty psychiatric hospitals. As wait time information is not being publicly reported, general hospitals can only find out wait times for specialty psychiatric hospital beds by directly contacting them. Otherwise, general hospitals do not know how long it will take to have their mental health patients admitted into a specialty psychiatric hospital or if wait times are improving or worsening compared to previous months.

Patients would also benefit from public reporting of wait times because some patients, such as those living between Ontario Shores in Whitby and CAMH in Toronto, might have several options where they can obtain mental health services.

4.1.4 Suicides Recorded While Waiting for Service

One of the most significant consequences of longer wait times is the potential of persons harming themselves. Ontario Shores and The Royal record the reason a person drops off of their wait lists, whenever this information is provided from the source of a person's referral.

We reviewed available records and found that in the last five years, Ontario Shores and The Royal are aware of seven people in total who died while waiting for a bed or an out-patient program. While the cause of death is not always provided to the hospitals, their records indicated that at least one person died by suicide while waiting for help. While one of the other specialty psychiatric hospitals has not been formally tracking such information, we found its records also showing that one person died by suicide before they could be admitted to a bed.

We identified an instance in which a person died by suicide two days before their planned admission into the hospital after a six-week wait. The individual's spouse had indicated in discussion with this

hospital's staff that they felt the individual's illness had played a factor in the suicide.

Because hospitals either do not record or are not always provided with information regarding the reason patients drop off their wait lists, the total number of deaths of individuals waiting for specialty psychiatric hospital services and their cause are not fully known.

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;
- collect wait time information for in-patient and out-patient programs; and
- publicly report this information.

MINISTRY RESPONSE

The Ministry accepts this recommendation and is working to standardize wait time definitions and collect wait time information for specialty psychiatric hospital services. Once a standardized definition for wait times is in place, wait time information will be collected, monitored and publicly reported for both in-patient and out-patient programs.

The Ministry is providing funding over three years (2014/15 to 2016/17) to the Centre for Addictions and Mental Health (CAMH) to support the Access to Care Initiative. The Mental Health and Addictions Access to Care Initiative (ATC)—a partnership among the specialty psychiatric hospitals—aims to address significant gaps in access to care by using data from the four hospitals to track specific wait times, identify service gaps, and build a structure for public reporting and accountability. The overall goal of the ATC initiative is to develop a comprehensive, province-wide approach to improve access to care for mental health and addictions patients.

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

While wait lists for admission to the specialty psychiatric hospitals are growing, more of their beds are being occupied by people who do not need the care they provide. The Ministry has not ensured that there are enough beds at other health care facilities (such as supportive housing for those with mental illness and in long-term-care homes) to care for patients who are ready to be discharged from the specialty psychiatric hospitals. This has resulted in more specialty psychiatric hospital beds being occupied by people who no longer need to be hospitalized and increased costs to the province as a result of caring for these patients in a hospital longer than was actually needed.

4.2.1 Specialty Psychiatric Hospital Beds Are Being Used by People Who Do Not Need Hospital Care

Instead of providing specialized mental health care, specialty psychiatric hospitals are now more and more playing the role of long-term-care homes for patients with dementia, brain injury or intellectual disability, or the role of supportive housing.

We found that in the last five years approximately one in ten beds in specialty psychiatric hospitals was occupied by someone who did not actually need hospital care but could not be discharged due to the lack of available beds in supportive housing or at long-term-care homes. Over the past five years this problem has become worse. We reviewed patient discharge information at each of the four hospitals and found that in 2015/16 it took them on average almost a year to transfer a patient to supportive housing or to a long-term-care home. This is an increase compared to 2011/12, when on average patients remained in the hospitals 235 days waiting to be transferred to supportive housing or a long-term-care home after no longer requiring specialty psychiatric hospital care.

Figure 10 shows the percentage of patients at each specialty psychiatric hospital that should have been discharged in 2011/12 and 2015/16. This percentage has increased in three of the four specialty psychiatric hospitals.

4.2.2 Timely Discharge Would Lead to Hospitals Seeing Hundreds More Patients

We compared the number of days patients were in each specialty psychiatric hospital while no longer requiring hospital care with the average patient length of stay at each hospital. Based on this comparison, we estimate that in 2015/16 alone if the four specialty psychiatric hospitals had been able to find a place to discharge their patients as soon as they should have been, they would have been able to admit and care for about an additional 1,400 people. This would significantly reduce wait times, especially for seniors.

Patients who get better and are ready to leave should therefore be discharged in a timely manner. This ensures that beds become open for those on the wait list and health care dollars are spent efficiently.

4.2.3 Shortage of Resources Delays Discharges

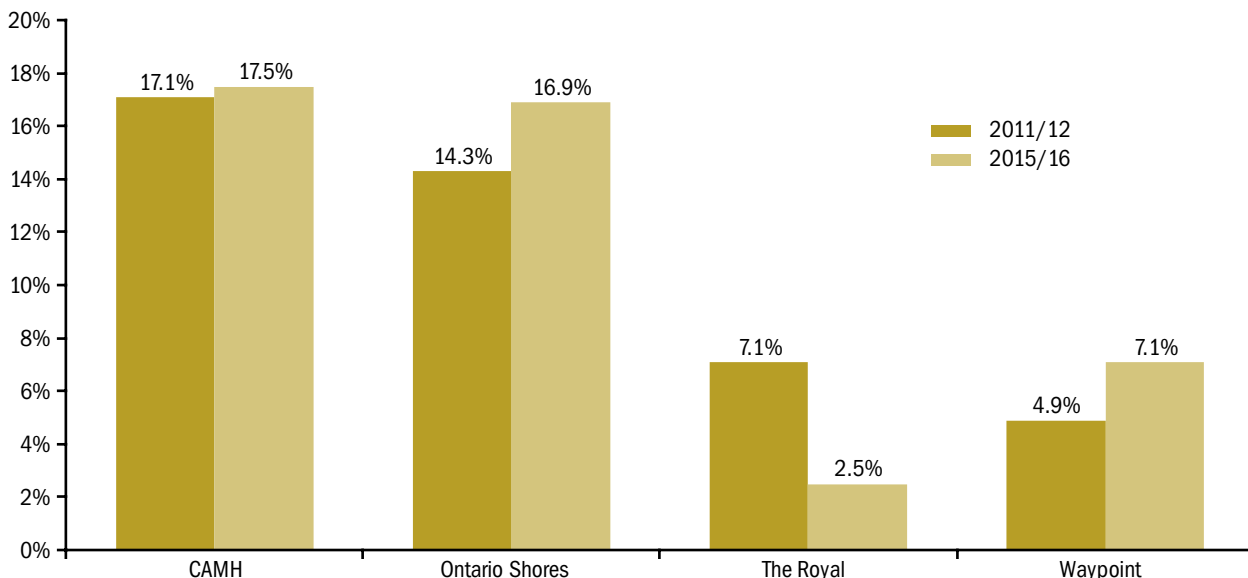
We spoke with representatives from three long-term-care homes about the challenges that they face with accepting patients from specialty psychiatric hospitals. They said that even when they do have open beds, they are sometimes hesitant to accept these patients because they lack properly trained staff, such as behavioral therapists, to look after them.

The problem of finding a place for these patients is further exacerbated by the fact that there is a greater demand for beds in general than supply at supportive housing and long-term-care homes. In our Hospital Operations audit included in this Report, (**Section 3.08 in Chapter 3**) we found that there were 1,854 people waiting in hospitals in Ontario for an open spot in a long-term-care home as at March 31, 2016.

In our audit of housing and supportive services for people with mental health issues (**Section 3.07 in Chapter 3**), we found that on the largest centralized wait list for supportive housing in Ontario, for every applicant that came off the wait list in 2015/16, nearly six new applicants joined the list.

Figure 10: Percentage of Beds Occupied during the Year by Patients Who Should Have Been Discharged* but Could Not Be, 2011/12 and 2015/16

Source of data: Specialty Psychiatric Hospitals



* As determined by the Specialty Psychiatric Hospital.

4.2.4 Discharge Delays Increase Costs of Care

Specialty psychiatric hospitals are designed to look after those who suffer from the most complex and severe mental illness. They provide the highest level of care, which is also the most costly.

In 2016, the average cost to care for a patient for one day at a specialty psychiatric hospital was about \$930. However, the cost to the Province of treating a patient at supportive housing or long-term-care homes ranged from \$68 per day for supportive housing to \$166 for a long-term-care home, which is less than one-fifth of what it costs to care for a patient at specialty psychiatric hospitals. In 2015/16, based on the difference in cost between treating a patient in a specialty psychiatric hospital and treating a patient in a nursing home or supportive housing, the cost of providing care that was no longer necessary was about \$45 million. Had patients been discharged from the specialty psychiatric hospitals as soon as they no longer needed hospital care, this money would have been used to care for patients on wait lists who actually need the specialized care offered by specialty psychiatric hospitals.

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.

MINISTRY RESPONSE

The Ministry is working to improve the services provided to people with mental illnesses and addictions along the continuum of care. The Ministry recognizes the important role of clinicians in discharging patients back to their

homes and communities, including long-term-care (LTC) homes and supportive housing, if patients require this level of support.

The government's Long-Term Affordable Housing Strategy, along with the Mental Health Leadership Advisory Council's work on supportive housing, will provide information and advice on addressing shortages of supportive housing for people with mental illnesses and addictions. The Strategy includes investing \$16 million over three years starting 2014/15 to create 1,000 new housing spaces for people with mental health or addictions issues.

The Ministry is working closely with the LHINs to monitor the need for LTC home beds throughout the province and is currently examining future needs for LTC home capacity and planning accordingly.

The Ministry is also developing a provincial capacity planning framework to support integrated and population-based health planning. The framework will support the Ministry, LHINs and health system partners by providing access to consistent data and guidance on planning activities. Once developed, the capacity planning framework will help support the provision of care in the most appropriate setting possible across the health-care continuum.

RESPONSE FROM LHINs

This recommendation encourages the Ministry and LHINs to continue their work together to address the capacity of specialized beds for patients with mental illnesses and addictions in LTC homes, and of supportive housing beds.

The LHINs' Provincial MH&A Advisory Committee has endorsed three pan-LHIN MH&A priorities, including the availability of flexible service support housing options for key populations. As well, LHINs have been active participants in the Ministry's Enhanced Long-Term Care Home Renewal Strategy.

4.3 Long-Term Psychiatric Beds Closed across Province

While patients no longer requiring the hospitals' specialized care take up more beds waiting for discharge, the number of beds in specialty psychiatric hospitals has decreased in the past five years. The result is that fewer patients who require their care are receiving it.

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.

4.3.1 General Hospitals Impacted by Bed Closures

We met with staff and management from three general hospitals located near CAMH and Ontario

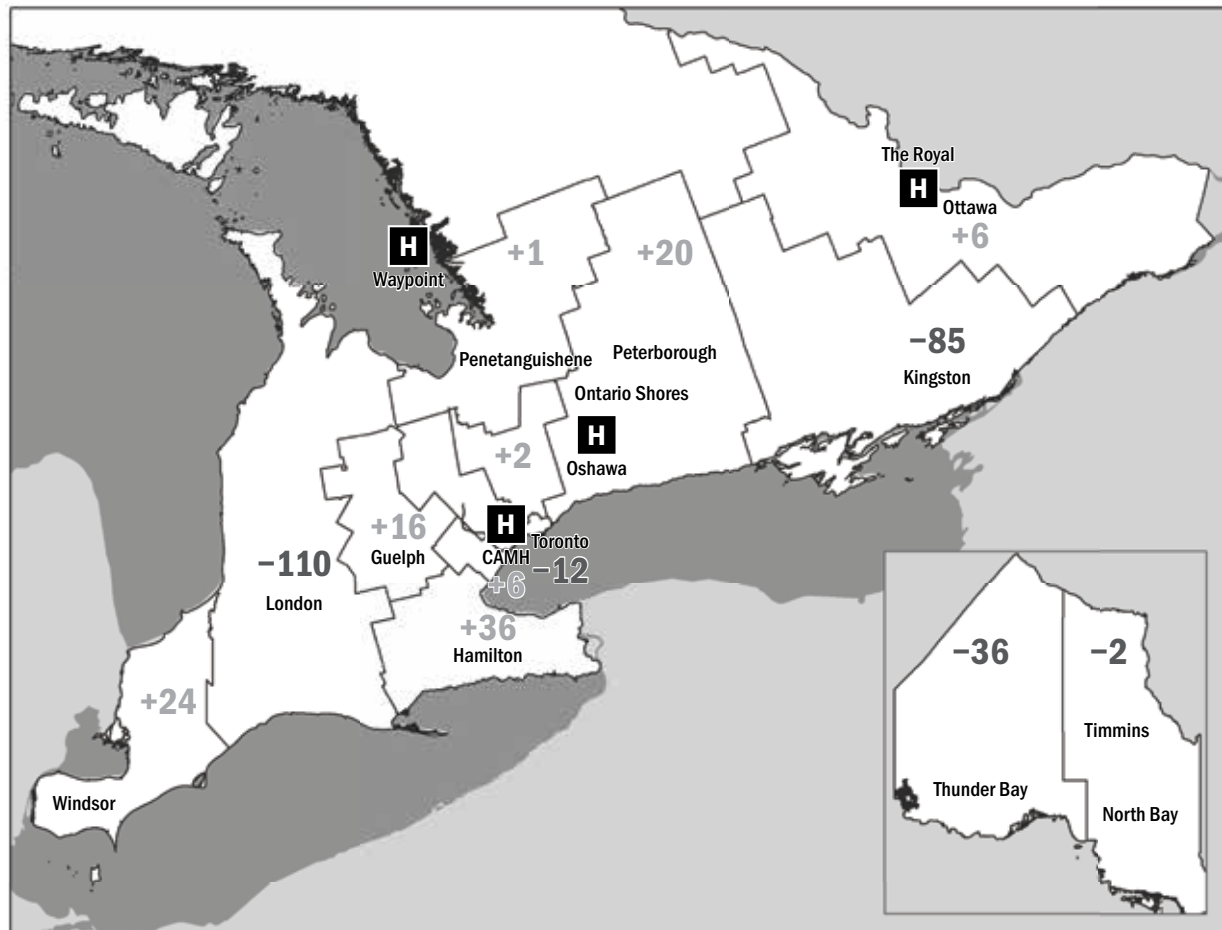
Shores to find out what impact these bed closures had on their patients. One hospital informed us that since the closure of CAMH's schizophrenia beds, they are having more trouble finding specialty psychiatric hospitals to which they can refer their patients with schizophrenia.

One hospital that is located close to Ontario Shores told us that there have been over 20 admissions into the hospital for mental health care as a direct result of beds closing at Ontario Shores. Another hospital said that it now has a harder time referring its patients to Ontario Shores. Staff said their hospital's emergency department patient length of stay has increased over the past few years. The hospital partially attributes this to the bed closures at Ontario Shores.

Overall, 5% of the long-term psychiatric beds that existed five years ago in the province have been closed. **Figure 11** shows the changes in the number

Figure 11: Change in the Number of Long-Term Psychiatric Beds between 2011/12 and 2015/16, by LHIN

Prepared by Office of the Auditor General of Ontario using data from Ministry of Health and Long-Term Care



of long-term psychiatric beds in each LHIN between 2011/12 and 2015/16.

4.3.2 Not Enough Long-Term Psychiatric Beds Available across Province

In 1988, the Ministry commissioned a report that recommended that the Ministry ensure all residents in Ontario have access to mental health services in their own communities, 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 is still not the case for sufferers of the most complex and severe forms of mental illness. For example:

- In the North Simcoe Muskoka LHIN, there are no dedicated mental health beds for children. This meant that in 2015/16, 129 children within the region had to travel outside of the LHIN (including regularly to North Bay, which can be over 300 kilometres away for some residents of the LHIN) to access in-patient services. This puts additional strain on families, who must now travel farther to spend time with their child while admitted to a hospital outside the region.
- Dedicated hospital beds for individuals with addictions are only available in six of the 14 LHINs. While the Ministry indicated that additional addiction beds might exist in other hospitals in different LHINs, it does not have enough information to determine the exact number of these beds in each LHIN or across the province used to treat addiction patients. Patients who cannot access hospital services for addictions must travel to a different region to access services, obtain services from community providers who might not be able to deliver as intensive a level of care as a hospital, pay for services from a private provider, or go without treatment.
- The lack of needed services in Ontario between 2011/12 and 2015/16 resulted in the Ministry spending almost \$10 million to

send 127 youth to the United States to obtain mental health services (primarily for severe eating disorders) as the needed specialty services were not available in Ontario. Additional programs and services were started in Ontario (such as Ontario Shores' program for children and youth with the most severe forms of eating disorders, which opened in 2014) during this time period to reduce the number of children needing to obtain mental health treatment in the United States.

Overall, the number of long-term psychiatric beds varies from one bed per 2,300 people in the Waterloo Wellington LHIN region to one bed per 90,200 people in the Central LHIN region. See **Figure 12**.

Figure 12: Number of Residents for Each Long-Term Psychiatric Bed, by LHIN (2016)

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

LHIN	# of Residents per Long-Term Psychiatric Bed ¹
Central	90,242
Mississauga Halton	78,649
Central West	66,808
Erie St. Clair	11,641
Hamilton Niagara Haldimand Brant ²	9,591
Champlain ²	7,321
Central East ²	6,941
South West ²	5,789
North East ²	5,620
South East ²	5,083
North Simcoe Muskoka ²	4,762
North West ²	4,718
Toronto Central ²	3,549
Waterloo Wellington	2,334
Average for Ontario	7,394

1. The province's 856 forensic beds are not included as long-term psychiatric beds. This is because they are used by eligible people regardless of the region where they live (that is, a bed in one region can be used by an eligible person from another region). To be eligible, a person must be referred to the bed by a court.

2. This LHIN has forensic beds in addition to long-term psychiatric beds.

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;
- set a target for the number of long-term psychiatric beds needed in each LHIN, monitor it regularly to ensure it is being achieved; and
- publicly report this information.

MINISTRY RESPONSE

The Ministry will work with LHINs on a capacity planning strategy that incorporates the supply and demand for long-term psychiatric beds in each local community and region. In addition, the Ministry is developing a capacity plan and will work to develop and release a target for long-term psychiatric beds by LHIN. This work will help support the provision of care in the most appropriate setting possible.

While the Ministry agrees that between 2011/12 and 2015/16 there was a net reduction of 134 long-term psychiatric beds across the province, over the same time period there was an increase in short-term (acute) psychiatric beds. Most of these beds were located in general hospitals, which were not looked at as part of this audit.

RESPONSE FROM LHINs

The LHINs agree there is a need to determine the number of long-term psychiatric beds required in each region of the province to meet the demand. Existing mental health capacity planning work conducted in some LHINs can be replicated in other regions to inform decisions

on service and capacity requirements. Capacity planning work should also consider the mental health and addictions programs that may be provincially accessed (for example, high-security forensic unit).

4.4 Ineffective Funding Results in Patient Needs Not Being Met

The Ministry decides on the total amount of funding for mental health care in Ontario. In 2015/16, that amount was \$3.3 billion.

4.4.1 Funding Not Based on Volume of Demand

Since 2012/13, the Ministry funds ongoing operations at most general hospitals based on the volume of services that they provide. This ensures that hospitals are better able to cope with the growth in demand for the health care services they offer.

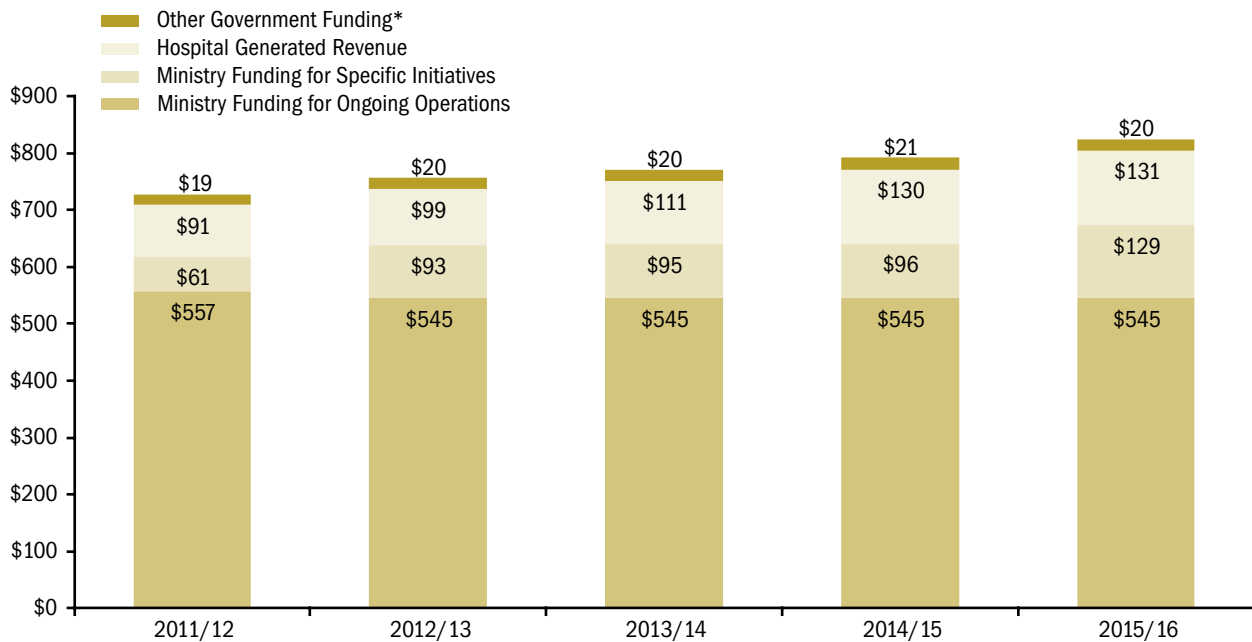
Funding for specialty psychiatric hospitals, however, is not tied to the volume of service they provide. Instead, the Ministry provides funding to the hospitals either for ongoing operations or to support specific initiatives. Such initiatives include specialty psychiatric hospitals training other staff who provide direct patient care in remote areas of the province.

The hospitals also receive dedicated program funding from other ministries and the federal government. For instance, in 2015/16, The Royal received about \$3 million from the federal department of Veterans Affairs Canada for a program to treat personnel of the Canadian Armed Forces or Royal Canadian Mounted Police who experience persistent psychological difficulty.

The hospitals also generate revenue on their own from sources such as parking and cafeteria sales. **Figure 13** shows total funding special psychiatric hospitals received and generated over the past five years.

Figure 13: Specialty Psychiatric Hospital Total Revenue Breakdown, 2011/12–2015/16 (\$ million)

Source of data: Specialty Psychiatric Hospitals



* Other Government Funding is comprised of \$2 million provided by the Ministry of Children and Youth Services for community mental health services for youth, \$15 million is from the Ministry of Community Safety and Correctional Services to provide mental health services to charged provincial offenders, and \$3 million is from the Department of Veteran Affairs Canada to provide mental health services to members of the Royal Canadian Mounted Police or the Canadian Armed Forces.

4.4.2 Limited Funding Increase Impacts Patient Care

For a period of five years, until April 1, 2016, the Ministry's funding for specific initiatives more than doubled (from \$61 million to \$129 million). However, dedicated Ministry funding for ongoing operations at the hospitals decreased by 2%, or \$12 million, from \$557 million to \$545 million, over the same period.

While the majority of specific initiative funding is not spent on ongoing operations, some of this funding is directed by the Ministry for use to expand an existing program or start a new program. For example, The Royal received over \$4 million between 2011/12 and 2015/16 related to the expansion of its forensic unit, including the addition of four beds. This funding can only be used for the specific purpose identified by the Ministry and cannot be used for any other purposes (including for any other ongoing program).

As such, in total, all ministry funding given to specialty psychiatric hospitals for ongoing operations increased by 3%, from \$572 million in 2011/12 to \$587 million in 2015/16. During this same time period, inflation (based on Statistics Canada's Consumer Price Index) was about 7%. To cope with this limited increase in funding for ongoing operations, the hospitals had to fund a greater portion of their ongoing operations from self-generated revenues, close beds and cut services, which has impacted patient care.

4.4.3 Ministry's Funding Decisions Not Based on Actual Demand

During our audit work, we were informed that for 2016/17, the Ministry provided each specialty psychiatric hospital with a 2% increase in funding, or approximately \$12 million, 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 specialty psychiatric hospital services as indicated by current and projected wait times. It is therefore not clear that a 2% increase is the appropriate amount.

The Ministry also did not do any analysis to verify that each hospital needed the same increase in funding. For example, some hospitals might have longer wait lists and therefore could benefit more from additional funding than other specialty psychiatric hospitals.

It is also not clear that the Ministry is considering the impact on other stakeholders when determining the amount of funding it is providing to each mental health service provider. For example, additional funding to specialty psychiatric hospitals can reduce the number of people going to general emergency departments for mental health reasons. Alternatively, specialty psychiatric hospitals would benefit if the Ministry provides more funding to supportive housing and long-term-care homes that can manage complex patients, to increase the number of beds available. This would enable specialty psychiatric hospitals to discharge patients sooner and open beds to more patients on wait lists.

4.4.4 Ministry Does Not Collect Sufficient Information for Funding Decisions

During our audit, the Ministry created a dedicated mental health and addictions branch. Prior to April 2016, mental health care decisions, such as those related to policy and funding, were decentralized and done within different Ministry branches that also deal with all other provincial health care services, such as general hospitals. While creating a dedicated mental health and addictions branch is a step in the right direction, for this branch to make appropriate decisions it needs information about the demand for mental health services and what services are currently offered.

We found that neither the Ministry nor the LHINs collect information from specialty psychiatric hospitals on what programs they offer, analyze how many patients of each mental illness diagnosis

they treat, or collect how long patients must wait to be admitted to a hospital or an out-patient program. Such information is necessary to support good funding decisions.

For instance, the Ministry does not have complete data on the different types of mental health beds across the province. While the Ministry knows the total number of long-term psychiatric beds that exist in the province, it does not know how many of each of these beds exist to treat each mental illness diagnosis. For example, when we asked the Ministry to provide us with the number of beds used to treat addiction patients in the province, the Ministry could only confirm that these types of beds exist in six LHINs. While the Ministry believes that other LHINs have long-term psychiatric beds that treat addiction patients, they currently do not collect enough information from hospitals to determine whether this is true.

4.4.5 LHINs Not Collecting Relevant Information

The Ministry provides funding to each LHIN to allocate to specialty psychiatric hospitals in their specific region. To ensure the funding received by the hospitals is being used appropriately, LHINs should collect and analyze relevant information to assess how well specialty psychiatric hospitals are providing care services that meet the needs of their patients. LHINs have not been doing this.

We found that LHINs use the same template to collect information from specialty psychiatric hospitals as they do from general hospitals. This template asks very little about mental health care that is provided by the hospitals, and is returned back to LHINs mostly blank. For example, the template asks specialty psychiatric hospitals to report the number of surgeries, MRIs and breast screenings to detect cancer that they perform, even though none of these services are offered by them.

As a condition of the funding they receive, specialty psychiatric hospitals enter into accountability agreements with their respective LHIN.

These accountability agreements, however, are not based on any targets related to reducing wait times or improving the quality of care received by hospital patients. Rather, hospitals are only required to admit and treat a certain volume of patients and have a balanced budget. This means that in theory specialty psychiatric hospitals could reach their patient volume target by operating programs that are low cost but have a high patient turnover, while they ignore demand for programs that are more costly but have a lower patient turnover.

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;
- 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; and
- 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.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will identify what linkages between the volume of service and funding could best support timely provision of these services, and, together with LHINs, will work toward developing a strategy to reduce wait times for these services.

The Ministry, in partnership with the LHINs, and using the advice provided by the Mental Health and Addictions Leadership Advisory

Council, is working to improve community mental health and addictions services. This will help to ensure that Ontarians receive services early in the course of their illness, which can prevent the need for more intensive and costly hospitalizations and provide better discharge planning for people to access services and supports after discharge from hospital.

Preventing unnecessary hospitalizations will decrease wait times for access to in-patient beds.

RESPONSE FROM LHINs

Appropriate and timely access to mental health and addictions services is a priority for LHINs. Through the annual Ministry-LHIN Accountability Agreement (MLAA) indicator review, the Ministry and LHINs will identify opportunities to improve performance monitoring for mental health and addictions. In turn, the LHIN Service Accountability Agreement (SAA) steering committees and indicator working groups will work to align provincial accountability indicators to local agreements.

Wait times are not only influenced by available beds and services, but also by appropriate patient flow, capacity and supports for transition. For example, creating appropriate capacity for affordable housing and housing supports is necessary for meeting the demands of this population. LHINs will work with the Ministry to identify investments and initiatives that would have the greatest impact on reducing wait times for specialty psychiatric hospital services.

LHINs will also work toward linking targeted services to wait times in the Hospital Service Accountability Agreements (HSAAs) between LHINs and Specialty Psychiatric Hospitals.

4.5 Spending on Direct Patient Care below Comparator Hospitals

With a growing demand for mental health care, it is important that specialty psychiatric hospitals manage health care dollars efficiently so that as much

funding as possible is spent on direct patient care (such as medication and the salary of nurses and other staff who provide direct care to patients).

4.5.1 Spending on Patient Care Declined Slightly

When we reviewed how specialty psychiatric hospitals spent Ministry-provided money for ongoing operations, we found that since 2011/12 spending 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 was spent on non-direct patient expenses. This includes expenses not directly related to providing patient care such as salaries for management, supplies and the hospital's information technology systems.

We compared this to the average amount that other comparator hospitals in the province spent on direct patient care. (Comparator hospitals are small community hospitals, which have had fewer than 2,700 acute in-patient or day-surgery cases per year in any two of the prior three years, and chronic-care or rehabilitation hospitals, which are stand-alone hospitals that provide complex continuing care or rehabilitation services.) In doing so, we found that specialty psychiatric hospitals spent about 5%, or 3 cents, less on direct patient care than the comparator hospitals in the province. We also found that while specialty psychiatric hospitals now spend about 2 cents less on direct patient care than they did five years ago, the provincial average of comparator hospitals remained constant. This suggests that overall, specialty psychiatric hospitals may be able to use more of the Ministry funds they receive on direct patient care.

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.

RESPONSE FROM HOSPITALS

The specialty psychiatric hospitals accept this recommendation and will conduct a comparative review with hospitals with similar therapeutic roles and settings to explore opportunities to shift more spending toward direct patient care, while recognizing our system's mandate to support the provincial mental health and addictions strategy and a legislative mandate to support the forensic mental health system. In addition, it is important to note that building finance models and IT infrastructure investments to deliver on provincial electronic medical record strategies contribute to overhead costs.

4.6 Differences in How Specialty Psychiatric Hospitals Provide Care

There are differences in policy among the specialty psychiatric hospitals impacting each hospital's criteria for admission, treatment methods and discharge planning.

4.6.1 Lack of Mental Health Standards Leading to Different Care Provided Provincially

Mental health standards help staff make consistent decisions regarding which patients to admit to specialty psychiatric hospitals, what treatment those patients should be provided and how and when those patients should be discharged. Mental health standards can describe what patient diagnosis requires hospitalization or alternatively can be treated through an out-patient program. These standards improve consistency in the care that people with the same diagnosis receive across different hospitals in the same region. While these standards exist in other jurisdictions such as Nova Scotia and the United Kingdom, they do not in Ontario and there is no timetable set to create them.

4.6.2 Hospitals Do Not Agree on Criteria to Admit Patients

In Ontario, each of the four specialty psychiatric hospitals develops its own standards pertaining to patient admission, treatment and discharge. These standards sometimes can differ. This leads to differences in how patients with the same diagnosis are regarded by each hospital.

We spoke with clinical staff at general hospitals that operate near the four specialty psychiatric hospitals who told us that it is common for specialty psychiatric hospitals to reject patients that the general hospitals thought should be admitted there. Staff at one general hospital told us that after this happened multiple times they stopped referring their patients to specialty psychiatric hospitals altogether and now continue to treat them to the best of their abilities. Another general hospital told us of instances when it referred the same patient to two different specialty psychiatric hospitals and the patient met admission standards at one hospital, but was rejected by the other. Mental health standards could reduce the risk of such things happening, as all specialty psychiatric hospitals would use the same publicly identified criteria to admit patients.

Standard Admission Tool Exists But Not Consistently Used

The Level of Care Utilization System (LOCUS) is a standardized tool that can be used by mental health service providers to help determine where a patient should be treated so that they get the care they need. An overall low score for a patient after completing LOCUS indicates there is little supervision of the patient's treatment required and the patient can live independently in the community. A high LOCUS score indicates the patient needs to be admitted into a specialty psychiatric hospital bed to receive more intensive specialized treatment.

The use of this tool helps ensure that only those patients that require hospital care are admitted. This is important, as specialty psychiatric hospitals provide the highest level of specialized psychiatric care, and their resources are limited and in high demand.

Although we noted that this tool has been used in the past, or is being used in some capacity at the hospitals visited, neither of the two hospitals whose patient records were reviewed (CAMH and Ontario Shores) was generally using or requiring this tool to be used by the referral source to help determine whether the hospital was the most appropriate place for the person to receive treatment.

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);
- how similar patients should be treated; and
- how and when they should be discharged from the hospital.

MINISTRY RESPONSE

The Ministry supports the provision of additional guidelines to support consistency of care, developed in close partnership with clinicians.

Health Quality Ontario has recently developed three condition-specific mental health standards for the purpose of ensuring high-quality care planning and delivery. These evidence-based standards are based on best practice recommendations for individuals with the following psychiatric needs: adults with a primary diagnosis of schizophrenia (Schizophrenia Quality Standard); adolescents and adults with a primary diagnosis of major depression (Major Depression Quality Standard); and individuals with dementia and the specific behaviours of agitation or aggression (Behavioural Symptoms of Dementia Quality Standard).

All three existing standards outline actions that hospitals can take through inter-professional collaboration to ensure quality and continuity in both care and discharge planning. They also explicitly recommend comprehensive intake assessments (including identification of all risk factors), timelines for consistent review of care plans and guidelines for documentation of all assessment and care plan data to facilitate careful transition between settings upon discharge. The Ministry will examine whether forthcoming mental health standards could potentially reference specialty psychiatric hospital settings more explicitly.

Furthermore, the Ministry looks forward to the recommendations from the Mental Health and Addictions Leadership Advisory Council in 2017 on how to improve system planning, coordination and integration of services.

4.6.3 Admission Assessments Not Always Completed

When admitting patients, staff at each hospital are required to perform a number of assessments to identify treatment needs. For instance, new patients go through a psychosocial assessment to determine their psychiatric history. When we reviewed the assessment process at CAMH and Ontario Shores, we saw that the process was similar at both hospitals. However, when we reviewed a sample of patient files, we found that close to half of the files at Ontario Shores were missing some of the required assessments and almost all of the files were missing some of the admission assessments at CAMH.

This suggests that either the assessments were done but not documented, or were not done. In both cases, this could result in proper care not being provided to a patient.

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; and
- 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.

RESPONSE FROM HOSPITALS

The specialty psychiatric hospitals accept this recommendation and recognize the importance and inclusion of admission assessments in a patient's care plan and are committed to continuing quality best practices in patient care and discharge plans. We will equally ensure that audits are regularly performed for compliance and quality standards in clinical records management, and take corrective action such as providing staff training as necessary.

4.6.4 Care Planning Process at Times Not Documented

The primary concern of hospital staff should be providing direct patient care. However, complete documentation on all aspects of a patient's care while in a hospital is also important in providing quality care to patients.

According to the College of Nurses of Ontario Documentation Practice Standards, "Documentation communicates to all health care providers the plan of care, the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions. It also demonstrates staff's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history."

Inadequate documentation regarding a patient's care can lead to patients not receiving optimal care. For example, if hospital staff are not aware of discussions that have been held between other hospital staff members or with the patient, or treatments that have been recommended or provided by other staff members, they might not provide treatment using the most optimal method that the patient prefers.

Each patient who is admitted to a specialty psychiatric hospital is required by the hospital to have a care plan. The Mental Health Commission of Canada describes care plans as a “crucial part of supporting and helping the process of recovery. They should not be distinct from the daily provision of care. They are a key mechanism by which a person's individual care and treatment can be developed, documented and shared with all those who are involved.” Both the Ontario Medical Association and Nova Scotia mental health standards also stress their importance.

Care planning involves the patient's care team identifying the patient's needs and risks (such as risk of attempting suicide) and then formulating specific goals of treatment for the patient and what actions need to be taken to achieve those goals into a care plan. All staff working directly with a patient are expected to contribute to the patient's care plan, along with the patient.

We reviewed a sample of patient files at two hospitals (CAMH and Ontario Shores). Based on this review, we identified deficiencies with the three main components of the care plan:

- Identified patient risks are not consistently incorporated into the patient's care plan.
- Care plans did not include necessary patient goals or actions that staff should take to treat the patient, such as recommended activities the patient should participate in or associated timelines for treatment.
- Care plans were not regularly updated to include a patient's treatment status or plans for continued treatment.

While the hospitals had policies regarding the completion of patient care plans, these were not being followed by staff. This could have been due to various factors, including a lack of staff time to both care for patients and complete all required documentation, or the need for staff to have more training on what documentation they are expected to do. We asked the hospitals where we performed patients' file reviews why these items were not occurring, even though they were part of the hospital's policy. The hospitals informed us that as a result of changes to their policies and processes, additional staff training was needed.

Patient Risks Not Always Included in Care Plans

During admission, each hospital is required to do a mandatory assessment of patients. During this assessment, key patient health and behavioural risks are identified. These risks should be documented in a patient's care plan.

In our review of a sample of care plans at the two hospitals we found that the hospitals did not have a formal process in place to ensure that all significant patient risks and needs identified were included in the patient's care plan. We also found that some plans were missing known patient risks. The missing information related to important matters such as, for example, the fact that a patient is at higher risk of choking on their food and needs to be supervised when eating, or concerns of violence for the patient towards self or others.

If such information is not included in a patient's care plan, it can potentially result in patients not receiving proper treatment or in harm to the patient or others.

Some Care Plans Completed Late and Missing Required Information

We reviewed a sample of care plans at Ontario Shores and CAMH and found that the requirements for care planning at each hospital differed. We also found that many plans were completed late or were missing required information. For instance,

while both hospitals require their staff to complete care plans when new patients are admitted, only Ontario Shores requires its staff to update the plan on a monthly basis.

About 40% of the care plans that we reviewed were not prepared at admission as required. More than half of the care plans we reviewed at Ontario Shores were missing patient-identified goals for their hospital stay, or these goals were not identified at the time of the patient's admission. Most of the samples we reviewed at CAMH lacked details on the status of patient goals and what action was taken to accomplish these goals. If there was a valid reason for this omission, such as the patient being unable to understand and communicate their goals, this was not noted.

We noted that standards in another jurisdiction (Nova Scotia) stated the importance of having care plans that include goals and outcomes for an individual along with a timeframe for treatment. However, the care plans we reviewed for patients at the two hospitals did not include any timelines with regards to how long it should take to accomplish the patient's treatment goals. This creates concern that patients might not be receiving care when they should.

Care standards in another jurisdiction, the United Kingdom, note the importance of mental health patients having access to meaningful and culturally appropriate activities and programs during their stay. Activities and programs can range from group therapy sessions, such as behaviour therapy, to mindfulness sessions or singing classes. Activities and programs that improve a patient's physical, cognitive or social skills can all contribute to their treatment and recovery. This jurisdiction's standards identify that these activities and programs should be available seven days a week and in the evenings as well.

Specialty psychiatric hospitals have facilities such as swimming pools, gymnasiums and basketball courts. At the two hospitals we visited and reviewed patient records, we noted that the care plans did not usually include any clear goals for the type or amount of activities and programs that

patients should participate in. We looked at the time patients were involved in specific organized activities and programs, which excluded any time spent with psychiatrists (which could be daily or several times per month) and discussions with social workers. From the files reviewed at CAMH, we noted on average that patients were involved in 2.5 activities and programs per week, for a total of less than three hours of activity time for the week. Patients at Ontario Shores participated in an average of five activities and programs per week, but the time spent at these activities was not always documented. While patient participation in programs and activities at specialty psychiatric hospitals is voluntary, staff should be identifying and including appropriate activities into each patient's care plan and encouraging patients to participate in those activities as research indicates that they can contribute to the patient's treatment and recovery.

Care Plans Not Updated; Records Missing of Care Plan Meetings

Those patient files reviewed that had goals in the care plans were not updated on a regular basis. At Ontario Shores, care plans are required to be updated monthly. For the sample of patient goals within care plans that we reviewed, we found that the patient goals went an average of six months without an update, with some goals not updated for more than a year. At CAMH, the patient goals we reviewed went an average of almost four months before an update, with some going without an update for as long as nine months.

We noted that other jurisdictions had standards that stressed the importance of regular, frequent care plan updates. For example, care standards in Nova Scotia require care plans to be revised weekly, or more frequently if required.

Staff meetings allow staff caring for a patient to learn more about the patient's condition and what treatment they have been receiving from other staff involved in the patient's care and to make plans for future patient care. These meetings also

allow staff to discuss and determine what treatment should be provided to ensure the patient's condition can improve and that the patient can be discharged from the specialty psychiatric hospital as quickly as possible.

Out of the two hospitals where we reviewed patient records, only Ontario Shores had a policy that required an initial care planning meeting to occur within three days of a patient's admission and subsequent meetings at least monthly. In a sample of patient records we reviewed at this hospital, we found that in most of the records the occurrence of the initial care planning meeting was either not recorded or when it was, the meeting was held much later than the hospital's policy required. Similarly, about 70% of the files we reviewed did not contain records of all subsequent monthly meetings.

CAMH has no policy that requires staff to hold care planning meetings. Hospital staff told us that in practice staff meet regularly to discuss each patient, for example, once a week or every two weeks, depending on the patient's needs. However, in most of our sampled patient files we found that the records and details of these meetings were missing. We also found that, when the meeting notes were documented, they generally contained very little information on what was discussed.

4.6.5 Discharge Planning Not Being Done at Time of Patient Admission

We reviewed a number of research journals that had studies identifying the importance of early discharge planning. They say that planning for a patient discharge should start as soon as a patient is admitted to a hospital, or very shortly thereafter. This way, there is a better chance that proper care, such as in supportive housing, will be available when the patient is ready to be discharged because the patient can be placed on a wait list sooner. This improves patient flow and ensures hospital resources are used more efficiently on only those patients who are in need of hospital-level care.

In our sample of patient records that we reviewed at Ontario Shores and CAMH, we found that both hospitals required discharge plans to be completed at, just prior to, or within three days, of admission. Our review of patient files at Ontario Shores indicated that discharge plans were completed but they were done late. On average, they were completed two months after a patient was admitted, with some plans not completed until right before the patient's discharge from the hospital. CAMH did not have a formal discharge plan document. Instead, information was scattered throughout the patient's file and we could not always determine when it was recorded or when, or if, a discharge plan was completed.

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

RESPONSE FROM HOSPITALS

The specialty psychiatric hospitals agree that care planning processes are integral to quality patient care and are continuously working on improving care planning. We are all at different stages of electronic medical record implementation, and these improvements in our data infrastructure have already begun to improve some care planning processes. We will continue to review and improve our care planning policies, and work to ensure our staff understand and comply with these policies, and, as we continue to optimize our clinical practices to improve patient outcomes, we will share best practices across the sector.

Programming for patients is an integral part of the recovery journey. Ensuring that patients have the skills needed to transition back to the community and improve employment and income opportunities is a key priority. All hospitals have programming embedded in their care plans and will continue to strive to improve access and availability of activities, and work to encourage patients to participate in therapeutic activities.

MINISTRY RESPONSE

Health Quality Ontario has recently developed three condition-specific mental health standards for the purpose of ensuring high-quality care planning and delivery. These standards are based on evidence-based best practice recommendations for individuals with various psychiatric needs. All three existing standards outline action hospitals can take through inter-

professional collaboration to ensure quality and continuity in both care and discharge planning. In addition, the standards explicitly recommend comprehensive intake assessments (including identification of all risk factors), timelines for consistent review of care plans, and guidelines for documentation of all assessment and care plan data in order to facilitate careful transition between settings upon discharge.

The Ministry will examine whether forthcoming mental health standards could potentially reference specialty psychiatric hospital settings more explicitly.

4.6.6 Hospital Treatment Methods Differ

Specialty psychiatric hospitals treat people with the most complex and severe mental illnesses, and consequently are at the forefront of mental illness treatment and research. A number of the specialty psychiatric hospitals have developed new treatment methods for specific mental illnesses that show improved patient care outcomes compared to other methods. For instance, Ontario Shores developed a new approach to treat certain schizophrenia patients that led to a decrease in the number of patients who were prescribed multiple anti-psychotic medications. Such medications have strong side effects.

We found that there is no process for hospitals to share new treatment methods developed by their peers. Neither are they required by the Ministry to adopt them. This has created a situation where existing treatment methods that could lead to better patient recovery are not available at some hospitals. **Figure 14** lists treatment methods developed by one specialty psychiatric hospital that have not been adopted by the other specialty psychiatric hospitals.

RECOMMENDATION 9

Specialty psychiatric hospitals should continue to develop treatment methods and establish an ongoing forum for sharing them with the

Figure 14: Treatment Methods Developed by Specialty Psychiatric Hospitals That Have Not Been Adopted by Any Other Specialty Psychiatric Hospital

Source of data: Specialty Psychiatric Hospitals

Specialty Psychiatric Hospital	Focus Area of Hospital-Developed Treatment Method
CAMH	<ul style="list-style-type: none"> • Dementia (focused on reducing aggression in patients) • Schizophrenia* • Youth psychotic disorders (including youth showing early signs of psychosis) • Mood disorder (bipolar depression)
Ontario Shores	<ul style="list-style-type: none"> • Schizophrenia* • Dealing with metabolic side effects of antipsychotic medication • Major depression in in-patients • Dementia with agitation and aggression in in-patients
The Royal	<ul style="list-style-type: none"> • Youth and mood disorders (focused on reducing the time patients are waiting to obtain treatment for these illnesses) • Substance abuse with any other mental illness

* Ontario Shore's treatment method is focused on the assessment and treatment of adults (18–64 years old) with schizophrenia and schizoaffective disorder in their in-patient and out-patient settings. CAMH's treatment method is focused on specific age groups (such as schizophrenia patients aged 60 years or older).

other specialty psychiatric hospitals and with other general hospitals who also provide mental health services.

RESPONSE FROM HOSPITALS

The specialty psychiatric hospitals accept the recommendation to continue improving standards in mental health across Ontario. Over the last few years, the four hospitals created the Mental Health and Addictions Quality Initiative, which has grown to 20 hospitals and has garnered interest from other provinces and internationally. The initiative includes a publicly reported quality scorecard and forum to share best practices. The four hospitals have also focused on the development of integrated care pathways in a number of areas to improve standardization. All have participated in the development of the recently launched three Health Quality Ontario quality standards in schizophrenia, dementia and major depression. We will continue to support the development of standards for mental health and addiction treatment and care, and look for opportunities to share this work outside of the specialty psychiatric hospital sector.

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

4.7.1 Ministry Has Not Set Sufficient Targets for Mental Health Services

The specialty psychiatric hospitals have publicly released (since 2011) a Mental Health and Addictions Quality Initiative scorecard that identifies critical performance indicators on mental health as determined by the specialty psychiatric hospitals. **Appendix 2** identifies the type of information these hospitals report in their scorecard. While this information has been publicly released for the past five years, neither the Ministry nor the LHINs have evaluated this information or set targets for the hospitals against the information they report.

While the Ministry has set targets focused on improving access to services at general hospitals, such targets do not exist for specialty psychiatric hospitals.

Only Two LHIN Targets Set by Ministry Related to Mental Health

The Ministry has only two targets directly related to mental health. The targets are meant to be used to assess access and availability of community services for mental health conditions and substance abuse in each LHIN. While the Ministry did not set a time frame for each LHIN to achieve the targets, the LHINs are expected to demonstrate progress in achieving each target. They are:

1. Out of all emergency department visits in a LHIN, only 16.3% or fewer visits should be repeat unscheduled emergency department visits within 30 days by patients with mental health conditions.
2. Out of all emergency department visits in a LHIN, only 22.4% or fewer visits should be repeat unscheduled emergency department visits within 30 days by patients with substance abuse conditions.

The Ministry monitors repeat emergency department visits by those with mental illness or substance abuse issues, as it believes access to effective community services for mental health and substance abuse conditions should help to reduce the number of repeat unscheduled emergency visits.

4.7.2 Repeat Visits to Emergency Rooms Increased

When we looked at how all the LHINs performed against the two targets, we found that over the past five years, repeat visits to emergency departments within 30 days for mental illness or substance abuse conditions increased.

Overall, emergency room usage for mental health reasons increased 21% (from 209,250 visits to 254,161 visits over the last five years), while Ontario's population grew by only 4% during the same period.

As a percentage of all emergency department visits, between 2011/12 and 2015/16:

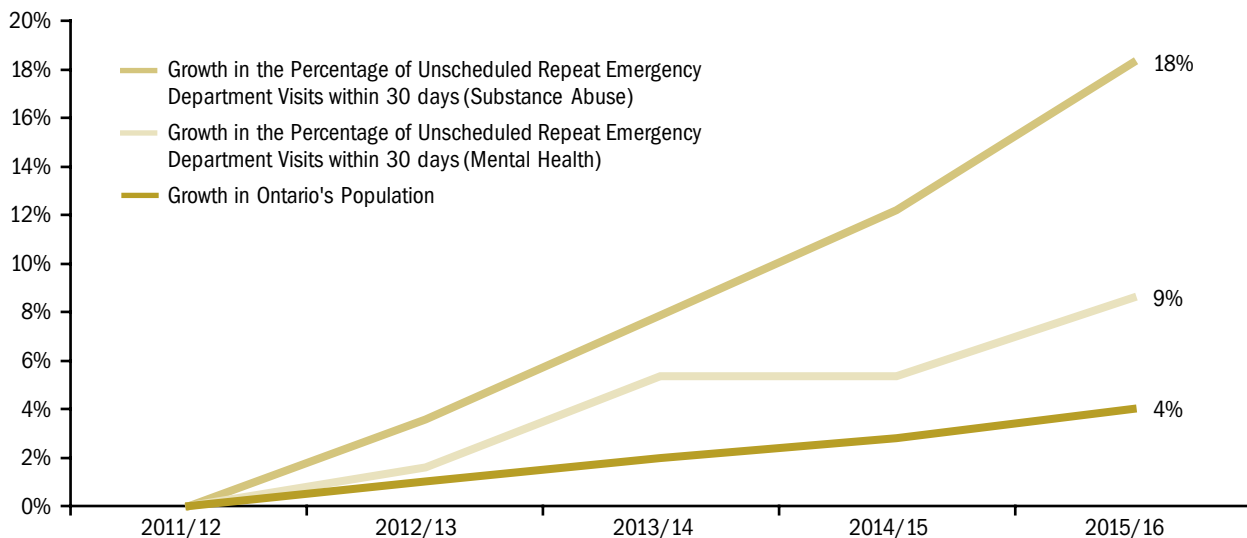
- repeat visits for substance abuse rose 18%; and
- repeat visits for mental illness rose 9%. (See **Figure 15**).

When we reviewed the percentage of repeat visits for mental health and substance abuse conditions compared to all emergency department visits separately for each LHIN, we found that:

- the percentage of emergency department visits that were repeat visits by patients with a mental health condition grew in 12 out of the 14 LHINs between 2011/12 and 2015/16;

Figure 15: Growth in the Percentage of Unscheduled Repeat Emergency Department Visits within 30 Days for Mental Health and Substance Abuse Conditions Compared with Growth in Ontario's Population, 2011/12–2015/16

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



- in 2011/12, there were five LHINs that met the province's 16.3% target, there were no LHINs that met this target in 2015/16 (see **Figure 16**);
- the percentage of emergency department visits that were repeat visits by patients with a substance abuse condition grew in 12 out of the 14 LHINs; and
- in 2011/12, there were five LHINs that met the province's 22.4% target, in 2015/16 there was only one LHIN that met this target (see **Figure 17**).

We asked the LHINs that oversee specialty psychiatric hospitals why the percentage of unscheduled repeat emergency department visits for mental health and substance abuse conditions in their respective LHIN increased between 2011/12 and 2015/16. A common reason raised by the LHINs was that the overall increase in

emergency department visits during the same time period for mental health conditions was 21%.

4.7.3 Ministry Does Not Know Reason for Increased Demand

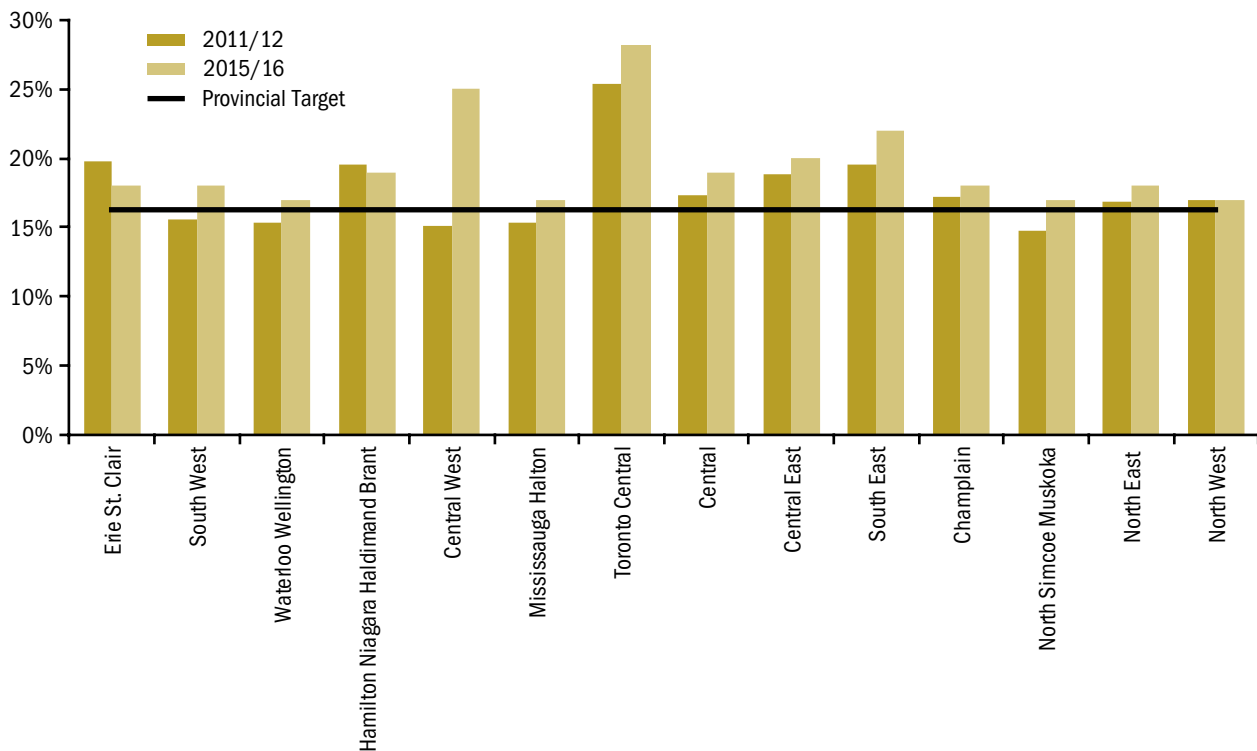
We asked the Ministry if it had conducted any analysis to determine why emergency department visits for mental health reasons had increased. It had not. Without performing this analysis, LHINs lack direction over how to reduce repeat emergency department visits in their regions.

Some of the LHINs informed the Ministry in writing that these targets were not useful as, alone, they did not provide enough information for LHINs to determine what changes they should make in their region to reduce emergency department visits.

For example, these targets give no indication whether specialty psychiatric hospitals should be

Figure 16: Percentages of Total Emergency Department Visits for Mental Health Conditions That Were Unscheduled Repeat Visits, by LHIN, 2011/12 and 2015/16

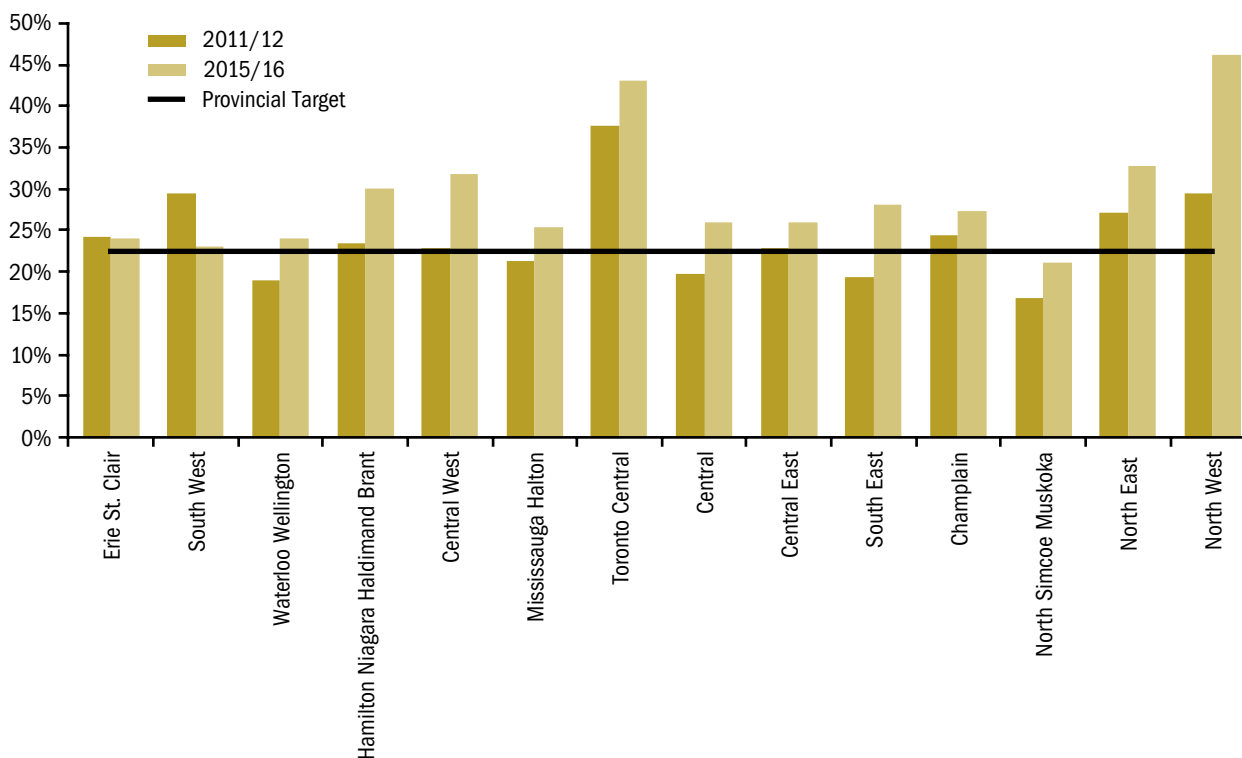
Source of data: Ministry of Health and Long-Term Care



Note: The black line represents the 2015/16 provincial target (no more than 16.3% of all emergency department visits for mental health conditions should be repeat unscheduled visits within 30 days of visiting an emergency department for a mental health condition).

Figure 17: Percentages of Total Emergency Department Visits for Substance Abuse Conditions That Were Unscheduled Repeat Visits, by LHIN, 2011/12 and 2015/16

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



Note: The black line represents the 2015/16 provincial target (no more than 22.4% of all emergency department visits for substance abuse conditions should be repeat unscheduled visits within 30 days of visiting an emergency department for a substance abuse condition).

providing more care to reduce repeat emergency department visits for mental health conditions. The LHINs requested that the Ministry revisit the usage of these two targets and identify alternative measures that would better reflect access and availability of mental health services in their communities.

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; and

- 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.

MINISTRY RESPONSE

In 2017, the Mental Health and Addictions Leadership Advisory Council will be making recommendations to the Ministry as to how to improve system planning, co-ordination and integration. A Data and Performance Measurement Task Group was struck by the Council to carry out this work. Members of the Task Group include experts in health systems data and performance measurement, experts in health and

public policy, and leaders from mental health and addictions community agencies and hospitals. The Task Group has developed a list of 10 indicators that the Ministry will consider as part of a more comprehensive data strategy, which will enable the assessment of accessibility, availability and effectiveness of mental health services.

4.8 Not Enough Mental Health Emergency Departments

The increase in number of repeat visits to emergency rooms within 30 days could be partially attributed to the lack of specialty mental health care emergency services.

CAMH has the only emergency department in Ontario that is exclusively for those experiencing mental health issues. This emergency department was first established in the 1960s. Although Ontario's population has doubled since then, no additional emergency departments currently exist elsewhere in the province.

Since 2011, visits to this emergency department have gone up by 40%, from 6,604 visits in 2011/12 to 9,252 visits in 2015/16. On average, patients must now wait an extra three hours, or about 40% longer, from 7.8 hours in 2011/12 to 10.8 hours in 2015/16 to be admitted into a bed at CAMH than they did five years ago.

4.8.1 Regular Emergency Rooms Not Best Alternative

Those who are not able to get to CAMH can seek immediate help at a regular emergency department. However, regular emergency departments indicated that they are not best suited to care for people with mental illness or addictions:

- Patients experiencing mental health or addiction issues have worse experiences when in chaotic environments, like loud and crowded emergency departments.
- Staff are generally less experienced at identifying mental illness.

- General emergency rooms are not set up the same way as a specialized mental health waiting room (bolted down chairs, security present) to ensure the waiting room is a safe environment for patients and others waiting for treatment.
- Patients cannot be transferred directly to a specialty psychiatric hospital and are forced to wait longer in facilities less able to meet their needs.

Police sometimes bring individuals with mental illness or addictions to the nearest emergency department. There, they must wait with the person until they are assessed by a doctor. In 2015, this took on average 80 minutes per visit. That is almost twice as long as when police brought an individual to CAMH's emergency department. The cost of the extra time police had to wait with an individual at regular emergency departments compared to at CAMH in 2015 was almost \$400,000. The extra time spent waiting also took time away from regular police duties.

While there are many benefits to dedicated mental health emergency rooms, including providing a safer experience to patients and allowing patients to directly obtain access to specialty psychiatric hospital beds, the Ministry has no plans to create additional ones across the province.

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.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will work with the LHINs and health service providers to develop appropriate solutions for improving the emergency services system for people with mental health and addictions issues, including appropriate spaces in emergency departments.

The Ministry is working to improve access to appropriate care for patients who use the emergency services system and require mental health services. Emergency departments are one component of a comprehensive emergency services system in Ontario that includes other components, such as EMS, CritiCall Ontario, Ornge, nursing stations and telemedicine. This emergency system already includes elements specifically tailored to mental health needs, including crisis response, assertive community treatment teams (ACTT), HealthLinks and other community providers.

CritiCall Ontario provides 24-hour-a-day emergency referral service for physicians across Ontario, facilitating advice (consultation) and effecting decisions (patient referral) for emergent, urgent and critically ill patients. In December 2015, CritiCall Ontario launched the provincial Adult Mental Health & Addiction Resource Board and accompanying Provincial Mental Health & Addiction Dashboard. The Resource Board and Provincial Dashboard provide up-to-date information about the number of available in-patient mental health and addiction beds in all Ontario hospitals that have mental health and addiction programs, including specialty psychiatric hospitals. For the first time, the Ministry, LHINs and hospitals have access to real-time data on the availability of mental health and addiction beds to improve access, patient flow and bed utilization. In addition, the Child and Adolescent Mental Health & Addiction Resource Board was launched in March 2016.

4.9 Lack of Patient Information Sharing

Patients with mental illness or addictions do not rely solely on specialty psychiatric hospitals for care. For example, patients in out-patient programs at the hospitals might also receive mental health services from community mental health agencies. It is also possible that during a patient's stay at a hospital, police might need to be called upon to intervene if a patient has assaulted another patient or staff member or if a patient has left without authorization from the hospital. It is therefore important that specialty psychiatric hospitals and other mental health stakeholders share information with each other that will allow patients to receive the best care in a safe manner.

4.9.1 LHINs Need to Have and Share Information Database for Patient Care

The Ministry has not ensured that the same level of co-ordination and information sharing exists throughout the province between the different mental health stakeholders. We noted that only one LHIN (Toronto Central) has a database whereby all providers of mental health services can look up patients' information to identify all the care and services that patients are receiving. This ensures patients receive the care that they require and prevents duplication of care.

4.9.2 Limited Information Sharing Increases Risks to Patients and Police

A similar problem exists with the sharing of patients' information with the police. For instance, some patients at specialty psychiatric hospitals are at risk for suicide or can become aggressive toward others. If these patients leave the hospital without authorization, they could pose a significant risk to themselves or to the public. In those cases, the police should be immediately notified when this does happen. Police informed us that this is not always the

case. Indeed, there have been times when they were not notified for up to six hours after a patient left the hospital without authorization or did not return to the hospital at a predetermined time.

Police also told us that some hospitals are not willing to share patient information, citing patient confidentiality requirements. Without this information, the police have to assume patients pose a high risk of danger to the public, which can lead to a more excessive use of force. We noted that the Ottawa Police Services had entered into a memorandum of understanding with the Ottawa Hospital, which is a general hospital. As part of this agreement, there were clear rules to govern information sharing between both parties to ensure patient privacy was protected while allowing both parties to do their jobs safely and effectively. While a similar memorandum of understanding exists between CAMH and the Toronto Police Service, the feedback we heard from police indicates that CAMH, as well as the other specialty psychiatric hospitals, can make improvements to the amount of information they share with local police departments.

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;
- 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; and

- 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.

MINISTRY RESPONSE

The Ministry will continue to work with LHINs to facilitate information sharing across the specialty psychiatric hospitals and LHINs.

The Ontario Common Assessment of Need (OCAN) mental health assessment tool has been implemented in 200 community agencies. Assessment information can, with patient consent, be uploaded into the Integrated Assessment Record (IAR), which also houses in-patient mental health, long-term care and Community Care Access Centre (CCAC) assessment information. Through the IAR, providers can access the same patient's information across various services. The Ministry is presently considering whether to mandate the use of the OCAN in all Ministry-funded community mental health agencies.

The Ministry will examine ways to improve information sharing with police. One opportunity is to build on the development of a Model Framework for location transitions protocols between police services and hospitals. The Framework was developed in partnership with the Ministry of Community Safety and Correctional Services (MCSCS), the Provincial Human Services and Justice Coordinating Committee (PHSJCC) and the Canadian Mental Health Association–Ontario Division. Once the Framework is launched publicly, a set of tools will also be released to assist with the development of police-hospital transition protocols, including information sharing where permissible under existing legislation, in Ontario communities.

RESPONSE FROM LHINs

The sharing and spread of effective practices across LHINs and health service providers is a

positive recommendation. Existing pan-LHIN groups could be leveraged for sharing information and consulting on policies, including the CEOs Council, Senior Directors Council and Provincial MHA Advisory Committee.

The LHINs already use information sharing systems, such as the Community Care Information Management System (CCIM), which enables information sharing between a patient's providers.

4.10 Staff Seek Improved Safety

As well as improving safety protocols when patients interact with police, improvements are needed in regard to staff's feelings of safety while working within the province's specialty psychiatric hospitals.

4.10.1 Staff Safety Concerns Not Resolved in a Timely Manner

Working directly with patients with the most severe and complex forms of mental illness, some of whom have no control over their behaviour and can cause physical harm to themselves or to others, can pose challenges for staff working at specialty psychiatric hospitals. That is why it is important for a hospital's management to take all the necessary steps to create a safe environment for staff and patients.

During our audit, we reviewed the results of staff surveys conducted at each hospital since 2014. In the latest survey results, almost 60% of 1,715 staff who responded from the four hospitals indicated that management is not taking effective action in response to reported safety incidents. This includes preventable incidents such as a nurse being burned after a patient got access to hot water, and a patient exiting a locked room without authorization through a poorly constructed door.

When we reviewed the hospitals' policies dealing with addressing reported incidents, we found that the hospitals do not require management to communicate with their staff about what actions they take to prevent all reported safety and security incidents from occurring again.

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

RESPONSE FROM HOSPITALS

The specialty psychiatric hospitals accept this recommendation and are committed to safe and healthy workplaces. A number of initiatives are already in place to enhance staff safety such as personal safety devices, training and regular risk assessments. We are currently working on enhancements like introducing Safewards as part of an intensive Safe & Well initiative. The hospitals will continue to explore other opportunities to enhance safety and will collaborate with their respective Joint Health and Safety Committees to improve staff safety. We regularly survey staff through bi-annual employee opinion surveys that encompass a variety of areas, including safety, and will continue to prioritize the survey feedback, including safety-related results, and action them accordingly. We will ensure communication processes are in place to inform staff of changes made to improve security and staff safety.

MINISTRY RESPONSE

The Ministry prioritizes patient and staff safety.

In August 2015, in partnership with the Ministry of Labour, the Ministry established a Workplace Violence Prevention in Health Care Leadership Table to better protect health-care professionals on the job. The Leadership Table consists of representatives from front-line

stakeholders, patient advocates and experts, as well as senior executives from both ministries and the health sector.

The Leadership Table will provide advice on how to reduce and prevent workplace violence for health-care professionals. To start, the Leadership Table focused on how to prevent violence against nurses in hospitals, followed by preventing violence against all hospital workers and in the broader health-care sector.

Based on the advice of the Leadership Table, an implementation plan will be developed to:

- make hospitals safer;
- reduce incidents of workplace violence in hospitals and the broader health-care sector;
- change attitudes toward workplace violence; and
- improve workplace safety culture regarding violence.

4.10.2 Waypoint's New Forensic Building Less Safe for Staff

While management's lack of response to safety concerns brought forward by hospital staff was an issue at all specialty psychiatric hospitals, one hospital, Waypoint, stood out as more significant from this group.

Waypoint has the only high-security forensic program in Ontario. This program has 160 beds to treat forensic patients who are deemed the highest risk of harming themselves or others. Patients are either referred to this program directly from court, or from forensic programs in other hospitals, because those forensic programs are not able to treat the patient in a way that maintains the safety of that patient, other patients and staff.

In May 2014, Waypoint relocated its forensic patients, including those being treated in their high-security forensic program, into a newly constructed building. The new building, constructed through a public-private-partnership arrangement delivered by Infrastructure Ontario at a cost of \$474 million, was supposed to offer a safe environment for both staff and patients.

Since the move, 90 deficiencies impacting staff and patient safety were identified. These deficiencies (including a poorly constructed fence and a broken electronic door-closing mechanism) contributed to more than 470 reported safety hazards (related to staff assaults, property damage, vandalism and a patient climbing over a fence and leaving without authorization) during the first year after relocation. This is almost triple the amount of safety hazards reported in the year prior to the relocation.

Results of a hospital survey conducted about half a year after the move showed that 85% of 108 staff surveyed who worked in the new building felt "not at all safer" compared to when they worked in the old building.

Between May 2014 and April 2016, the Ministry of Labour issued 12 compliance orders to address safety issues that occurred in the new building. Seven of these orders were related to two incidents that involved staff being assaulted or injured, including one incident where a staff member was stabbed by a patient. Although in year two after the relocation reported safety hazards have declined, they still are more than double the amount that was reported in the year prior to the relocation.

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;
- communicate this plan to staff; and
- regularly update staff on deficiencies that have been resolved.

WAYPOINT RESPONSE

Waypoint agrees that staff should feel safe and has prioritized, tracked and developed plans to ensure the Atrium Building is safe as part of its

corporate strategic plan, with 90% of the deficiency items on the tracking report addressed as of October 2016. Staff survey results indicate that overall staff perception of safety one year after the relocation exceeded levels in the old building. The hospital will continue to include staff in addressing design concerns, and track and communicate resolution. The hospital in conjunction with its Joint Health & Safety Committee has agreed to undertake a third external risk assessment that will inform future actions and plans in regard to staff safety, and will be communicated to staff.

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

To provide proper care, hospitals need to have the right number of nurses, psychiatrists and other staff who directly work with patients. We found that between 2011/12 and 2015/16, the number of staff across all four hospitals who provide care to admitted patients remained mostly unchanged. At The Royal, staffing decreased by 5%, and at Waypoint by 2%. The number of staff increased at CAMH and Ontario Shores by 5%. While over this same period of time the four hospitals closed 32 beds, the overall change in staffing at the four hospitals was fairly minimal, which resulted in their combined staff to patient ratio remaining about the same at two staff to three patients.

4.11.1 Not Enough Staff for Activities

While the overall staff to patient ratio remained about the same, staff and patient survey results from the four hospitals indicate that there is not enough staff in some programs. In surveys conducted at each specialty psychiatric hospital since 2014, half of the 3,361 staff surveyed indicated that they do not have enough time to do their job, and almost two-thirds of the 594 patients who responded to a question regarding organized activ-

ities (like group therapy) during the weekends indicated that there were not enough. We reviewed a sample of patient files at CAMH and Ontario Shores that indicated that only 20% of patients at the former hospital and 40% of patients at the latter hospital participated in activities over the weekend. While the overall staff to patient ratio remained mostly unchanged at the specialty psychiatric hospitals between 2011/12 and 2015/16, the hospitals do not have target staff to patient ratios, making it unclear if current staffing levels across the hospitals are appropriate.

4.11.2 Fewer Staff Are Full-Time

We also saw that over the past five years hospitals shifted towards hiring more part-time staff and that the mix of full-time and part-time staff varies between the hospitals.

Although part-time staff can provide equally valuable care, we came across a number of studies in research journals that found that a greater usage of full-time staff over part-time staffing results in better care for the patients with mental health issues because the patients get to build a longer-term therapeutic relationship with their full-time care providers.

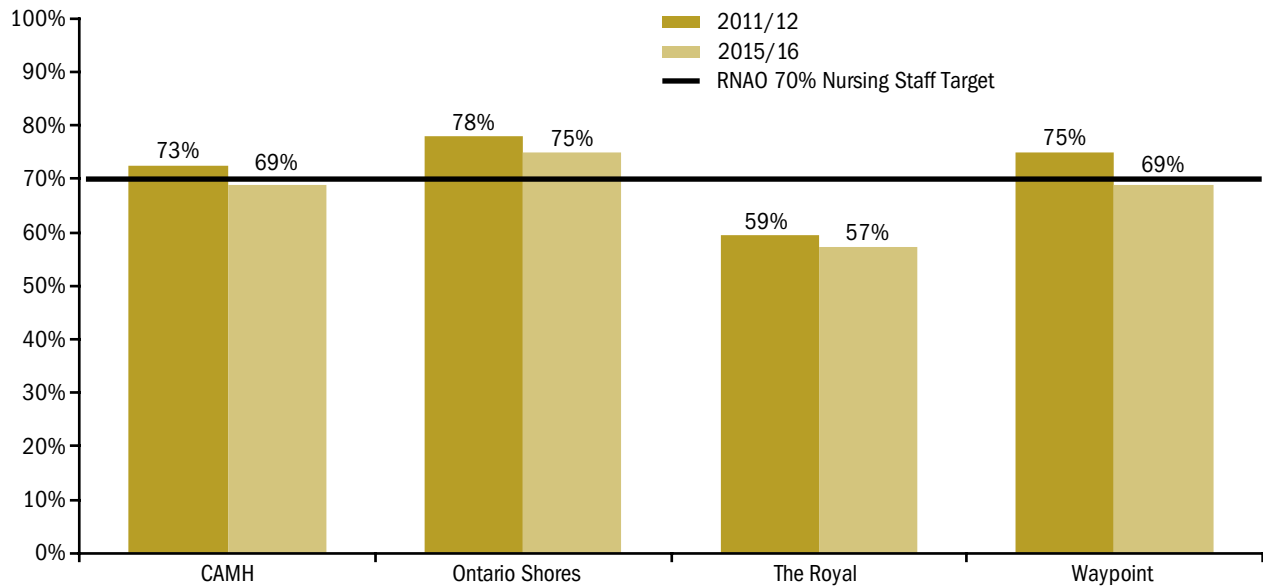
The Registered Nurses Association of Ontario (RNAO) has for the past few years consistently recommended that 70% of all nursing staff should be full-time to achieve best-quality care results. Three specialty psychiatric hospitals employed more than 70% of their staff that provide care to in-patients on a full-time basis in 2011/12. Five years later, one of the hospitals was above this ratio, and all had fewer full-time staff as a percentage of overall staff than they did five years earlier.

Figure 18 shows the change in full-time staffing levels at specialty psychiatric hospitals in 2011/12 and 2015/16.

Specialty psychiatric hospitals do not have staffing targets for their program units. This makes it difficult to determine whether hospitals have the most effective full-time to part-time staff composition.

Figure 18: Percentage of In-Patient Direct Care Staff that Are Full-Time, by Specialty Psychiatric Hospital, 2011/12 and 2015/16

Source of data: Specialty Psychiatric Hospitals



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; and
- use this information when making hospital program staffing decisions.

RESPONSE FROM HOSPITALS

The hospitals accept this recommendation and will continue to track useful program staffing information consistent with the Ontario Hospital Reporting Standards. We also commit to undertake a best-practice literature review

about staffing in specialty psychiatric hospitals to check against current practices and support transparent decision-making to meet patient care needs. We will use this information for the guideline development where relevant for staff-to-patient ratios and full-time to part-time staffing compositions.

The specialty psychiatric hospitals are also committed to the highest quality care, as well as benchmarking, as evidenced in the Mental Health and Addiction Quality Initiative. Staffing in a specialized mental health facility requires clinicians with the best skill set to work with people with severe and treatment-resistant mental illness. During the past years, we have witnessed significant increases in acuity in individuals with complex mental illness. As a result, there have been changes to address patients' clinical needs, as well as provide for a safe and therapeutic milieu for patients and staff.

Appendix 1: Specialty Psychiatric Hospital In-Patient Wait Times, 2015/16¹

Source of data: Specialty Psychiatric Hospitals

	Wait Time (Days) ²
Ontario Shores	
Treatment for forensic patients' reintegration into the community in a secure setting	268
Youth specialized eating disorder program	105
Adults suffering from mental illness and a developmental disability	68
Geriatric patients with dementia	32
Geriatric patients with severe or complex mental health needs	27
Adults aged 18 to 35 suffering from mental illness and substance abuse	17
Adult specialized neuropsychiatry program	15
Adults with serious and persistent mental illness, including ones who are treatment resistant	14
Youth general mental illness	13
Assessment of diagnosis and stabilization of mental health symptoms for adults	12
General program for forensic patients in a secure setting	6
Assessment of forensic patients required by courts	1
Assessment of forensic patients required by courts and treatment for patients' reintegration into the community in a secure setting	1
General program for forensic patients	0
The Royal	
Adults requiring recovery-based treatment due to prolonged illness and long hospitalizations	80
Adults suffering from mental illness and substance abuse	43
Adults with mood and anxiety disorders	6
Adults with schizophrenia	6
Geriatric patients with severe or complex mental health needs	4
28-day adult addiction treatment program	2
Crisis unit for outpatients requiring urgent care	1
Youth general mental illness	1
Treatment unit located at Ottawa site for forensic patients	0
Treatment unit located at Brockville site for forensic patients	0
Waypoint	
Adults suffering from mental illness and substance abuse	85
General program for forensic patients	48
Adults suffering from mental illness and developmental disability	18
Adults with severe and persistent mental illness receiving psychosocial rehabilitation	12
Geriatric patients with signs and symptoms of a psychiatric disorder or adult patients with Alzheimer's	11
High-security program for forensic patients suffering from mental illness and developmental disability	6
Assessment of forensic patients required by courts	5
Short-term assessment of diagnosis and rapid stabilization of mental health symptoms	5 hours
Secure program for forensic patients	0
High-security program for forensic patients diagnosed with mental illness and/or substance abuse	0

1. CAMH does not centrally collect or track in-patient wait times. 70% of CAMH in-patient admissions are directly from its emergency department. The wait time information is not fully comparable between hospitals. The Royal's wait time tracks how many days from the date a psychiatrist determines a patient should be admitted into the hospital to the date of the in-patient's admission. Ontario Shores and Waypoint begins tracking their wait times from the date that the patient's referral was received.

2. The hospitals measure median wait times of programs. Therefore, half of the people admitted waited longer than the days listed below.

Appendix 2: Mental Health and Addictions Quality Initiative Scorecard Indicators

Source of data: Specialty Psychiatric Hospitals

		2011/12-2015/16 Trend by Specialty Psychiatric Hospital			
Performance Indicator Category	Description	CAMH	Ontario Shores	The Royal	Waypoint
Patient Complexity	Three indicators that measure the percentage of patients seen by the hospitals that have more than one psychiatric diagnosis, or both a medical and psychiatric diagnosis.	Increase in the complexity of mental health of patients treated (the percentage of patients admitted with more than one mental health condition grew from 62% to 70%).	Increase in the complexity of mental health of patients treated (the percentage of patients admitted with more than one mental health condition grew from 56% to 89%).	Decrease in the complexity of mental health of patients treated (the percentage of patients admitted with health condition decreased from 59% to 44%).	Increase in the complexity of mental health of patients treated (the percentage of patients admitted with more than one mental health condition grew from 37% to 55%).
Patient Outcomes	Five indicators: three measure improvement in a patient's condition between admission and discharge, and two measure the readmission rates for patients within 30 days of discharge from the hospitals.	Decrease in the ability of patients who were discharged from the hospital to care for their mental illness independently (the percentage of patients who were able to do this more successfully upon hospital discharge decreased from 67% to 56%).	Decrease in the ability of patients who were discharged from the hospital to care for their mental illness independently (the percentage of patients who were able to do this more successfully upon hospital discharge decreased from 59% to 41%).	Increase in the ability of patients who were discharged from the hospital to care for their mental illness independently (the percentage of patients who were able to do this more successfully upon hospital discharge increased from 35% to 66%).	Decrease in the ability of patients who were discharged from the hospital to care for their mental illness independently (the percentage of patients who were able to do this more successfully upon hospital discharge decreased from 65% to 62%).
Patient Safety	Three indicators: one measures the percentage of patients who leave the hospital without authorization; one measures the percentage of patients whose medications are reviewed at admission (which reduces the risk of a patient being given improper medication during their hospital stay); and one measures what percentage of patients did not need to be restrained during their admission to the hospital.	Decrease in the percentage of patients who have had their medication reviewed at admission (from 92% to 88%).	Increase in the percentage of patients who have had their medication reviewed at admission (from 91% to 99%).	Increase in the percentage of patients who have had their medication reviewed at admission (from 58% to 100%).	Increase in the percentage of patients who have had their medication reviewed at admission (from 76% to 93%).

2011/12–2015/16 Trend by Specialty Psychiatric Hospital

Performance Indicator Category	Description	CAMH	Ontario Shores	The Royal	Waypoint
Patient Access*	One indicator that measures what percentage of all the patients at the hospital should be discharged from the hospital but cannot due to the lack of long-term nursing home beds or supportive housing.	Increase in patients who no longer need hospital care but cannot be discharged (from 13% of all patients at the hospital to 18%).	Increase in patients who no longer need hospital care but cannot be discharged (from 14% of all patients at the hospital to 17%).	Decrease in patients who no longer need hospital care but cannot be discharged (from 8% of all patients at the hospital to 7%).	Increase in patients who no longer need hospital care but cannot be discharged (from 5% of all patients at the hospital to 7%).
Staff Safety	One indicator that measures staff time away from work due to injury.	Decrease in the number of Workplace Safety and Insurance Board claims per 100 employees (from 2.1 to 1.7).	Decrease in the number of Workplace Safety and Insurance Board claims per 100 employees (from 5.9 to 5.0).	Decrease in the number of Workplace Safety and Insurance Board claims per 100 employees (from 2.0 to 1.1).	Decrease in the number of Workplace Safety and Insurance Board claims per 100 employees (from 3.3 to 1.8).
Staff Absenteeism	One indicator that measures staff sick time.	Decrease in percentage of staff time for sick leave (from 2.8% to 2.0%).	Decrease in percentage of staff time for sick leave (from 5.7% to 5.5%).	No change in percentage of staff time for sick leave (remained constant at 3.2%).	Increase in percentage of staff time for sick leave (from 4.5% to 5.7%).
Financial	One indicator that is the percentage of budgets in the last five years that were balanced.	All budgets were balanced.	All budgets were balanced.	All budgets were balanced.	All budgets were balanced except for 2013/14 (\$664,000 deficit).

* The Patient Access indicator reported in the Mental Health and Addictions Quality Indicator Scorecard for CAMH and The Royal is different than the percentages reported in Figure 10 of this report, which were calculated by our Office. The percentages calculated by The Royal and CAMH do not include complete information. For the Scorecard, The Royal excludes patients in the Forensic Treatment Unit in its Brockville location from its calculation. In Figure 10, we identified The Royal's percentages as 7.1% in 2011/12 and 2.5% in 2015/16. Due to data quality issues, CAMH's calculation of this percentage in 2011/12 as 13% was inaccurate and not comparable to the results it reported in subsequent years. CAMH agrees that the proper percentage of these patients was 17.1% in 2011/12, which matches what we report in Figure 10.