ABOUT THE AGHPS

The AGHPS was established in 1982 to address three issues:
• Recognition of the major role of general hospital services in providing psychiatric/mental health care in Ontario
• Identification of unique management issues in general hospital mental health services
• Realization that collectively general hospital mental services lacked a distinct voice in provincial and local policy making

Since 1982, the AGHPS has actively represented and advocated for mental health professionals within General Hospital / Schedule I facilities. In all of our activities, the Association seeks to reflect the concerns and views of its members and to ensure that general hospital psychiatry/mental health issues are accurately represented. We strive to ensure members have appropriate information, resources, support and input to policy making at all levels. Our Board of Directors is typically comprised of Chiefs of Psychiatry and Directors of Hospital Mental Health Programs throughout Ontario.

In 2010, the Organization underwent a significant transformation. Recognizing the increasingly complex challenges facing Schedule I hospitals within the context of a changing health care system there was a conscious decision to target resources into strategic activities and to align the AGHPS with the new reality.

Specifically, we:
• Clarified our mandate
• Upgraded our technology to enable a closer connection to Schedule I hospitals
• Addressed advantages of membership
• Provided an annual platform to bring leaders together and strengthen the voice of hospital mental health/psychiatry

A review of the AGHPS mission demonstrated a renewed commitment to the fundamental principles articulated by the founders of the Organization. We have retained the original mission.
MISSION

To promote the continuing development of optimal psychiatric services in Ontario by enhancing the role and effectiveness of general hospital psychiatric services. The Association will increase the knowledge and skill of member hospitals. It will provide a co-ordinated and effective voice on issues relevant to the delivery of psychiatric services.

The Association will endeavour to achieve these aims through mutual support among members and effective liaison with government, allied health care associations and other services and programs, both institutional and community based.

The AGHPS strategic priorities cluster into four major categories:
• Communication, Education and Training
• Expert Consultation and a collective voice
• Provincial Committees, Task Forces and Collaborations
• Guidelines, Checklists and Positions

We understand that as a community resource, general hospital psychiatric (mental health) services provide the highest concentration of expert resources available to patients, families, friends, family physicians, community agencies, ambulance and police. The community looks upon us to assess and treat the mentally ill, stabilize harmful behaviour, and sometimes, save lives. Emergency departments do not turn anyone away. In most communities, we are the only mental health resource accessible on a 24-hour basis.

The AGHPS mandate is to support Schedule I leaders as they oversee the day-to-day challenges confronting clinical best practice, systems and operations. We represent and speak for the professionals leading and serving within the unique Schedule I hospital environment.

Although membership is voluntary we currently represent approximately 65%-70% of all Schedule I hospitals. This is the largest assembly of professional mental health hospital leaders in Ontario. We are proud that we also extend our reach through robust relationships with stakeholders in many provincial and national Organizations.

The AGHPS promotes:
• Recognition of the full breadth of our vital role in community life
• An accurate reflection of our strengths, and our vulnerabilities
• A heightened understanding of our leading position in the mental health system

This year we will host our 8th Leadership Summit. This annual forum has become well established and valued for many reasons but primarily as an opportunity to build networks and provide a platform for information sharing, important discussion and acknowledgment of individual and organizational excellence.
ENVIRONMENTAL SCAN PROJECT

Project Purpose
The AGHPS focuses exclusively on vital issues confronting Schedule I leaders and we develop our strategic and operational activities to precisely mirror those efforts. We identify specific projects with clear outcomes based on member challenges and priorities. This approach ensures we stay focused on our mandate and mission and remain helpful to our members. Given our close relationship with Schedule I leaders we felt confident in our understanding of current issues and challenges. However, we also recognized that our understanding of the systems and practices in hospitals throughout Ontario was somewhat sporadic and anecdotal. We knew a little about a lot. We required a deeper and more consistent understanding of important strategic priorities. There was no resource available to us and it became apparent that there was no such provincial profile. While we were aware of remarkable initiatives in individual hospitals, no one had woven together the pieces into a collective portrait of the current state. We believed that this integrated profile would be useful to individual hospital and leaders for their internal planning. It would be useful to external Organizations and governmental agencies in system planning and it would guide the priorities and activities of the AGHPS over the next 2-3 years. Therefore we scoped out a project to construct a comprehensive environmental scan on several strategic issues.

Project Description and Outcome:
We will go beyond a survey to interview leaders from Schedule I hospitals. The result will be a qualitative summary of current practices as they relate to predetermined high priority issues. This will increase our understanding of the current landscape and inform a deeper understanding of how to collectively move forward. It will provide a foundation for Schedule I leaders and the AGHPS in guiding significant activities such as:

- Offering information and supporting decisions from Schedule I leaders
- Setting relevant program for Leadership Summits
- Informing the content for online educational activities
- Directing the AGHPS in providing endorsements, developing provincial best practices, protocols, positions, tools and standards

Project Objective:
To develop a comprehensive snapshot and detailed understanding of structures, systems, and practices on several strategic issues in Schedule I hospitals. The resulting qualitative data will provide information, insight and direction for the AGHPS, Schedule I hospital leaders and other stakeholders.
Project Design
Overview
- Phase 1: Determine the topics and design the questionnaire
- Phase 2: Interview Schedule of leaders
- Phase 3: Discussion and Findings
- Phase 4: The report
- Phase 5: Determine strategies on how to use the information to guide the AGHPS agenda

Determining Topics and Interview Design
The following outlines the process used to determine the topics and questions for the interviews
- Board and stakeholders were consulted to determine 2-4 topics for investigation
- Research on a Theoretical Domains

Framework approach to evidence based indicators (Rebecca Lawton1, 2016)
- Designed questions to obtain the information required
- Tested the interview instrument
- Finalized content and process for interviews
## SECTION 1: Health Quality Ontario (HQO) Statements

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>DOMAIN</th>
<th>QUESTIONS</th>
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</table>
| **Topic: Follow up within 1 week of discharge** | **Schizophrenia:** Adults with a primary diagnosis of schizophrenia who are discharged from an inpatient setting have a follow-up appointment within 7 days | 1. Currently, does every patient with a primary dx of Schizophrenia or major depression have a f/u appointment within 7 days?  
2. How is this managed / measured? |
| | **Major Depression:** People with major depression who are discharged from acute care have a scheduled follow-up appointment with a health care provider within 7 days | |
| | **Status** | 1. Are you aware that the provincial Quality Standards for Schizophrenia and Major Depression include this benchmark?  
2. Can you describe what typically happens in your hospital? |
| | **Knowledge** | 1. Do you have policies/protocols for discharge follow up for these 2 populations?  
2. Can you elaborate on the logistics (what happens)? |
| | **Skills** | 1. Are you planning to implement / change/ enhance your Organization’s practices to ensure f/u within 7 days of discharge?  
2. Do you have any documents/tools (and if so would you be willing to share with other Schedule 1’s)? |
| | **Intention/ Priority/ Plans** | 1. What specific to your Organization is helpful with regards to offering follow up within 7 days?  
2. Are there specific things that would further enable your practice? |
| | **Enablers** | 1. What specific to your Organization are the barriers (if any) with regards to offering follow up within 7 days?  
2. Are there specific things that would reduce those barriers? |
| | **Barriers** | 1. As a provincial organization how could the AGHPS be helpful to you?  
2. Do you have suggestions on how that could be done? |
<p>| | <strong>Role for AGHPS</strong> | |</p>
<table>
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<tr>
<th>TOPIC</th>
<th>DOMAIN</th>
<th>QUESTIONS</th>
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<tbody>
<tr>
<td><strong>Quality Statement:</strong> Schizophrenia Cognitive Behaviour Therapy - Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered individual cognitive behavioural therapy for psychosis either in the inpatient setting or as part of a post-discharge care plan.</td>
<td>Status</td>
<td>1. Currently, is every patient with a primary dx of Schizophrenia offered individual cognitive behavioural therapy? 2. How is this managed / measured?</td>
</tr>
<tr>
<td></td>
<td>Knowledge</td>
<td>1. Are you aware that the provincial Quality Standard for Schizophrenia includes this benchmark? 2. Can you describe what typically happens in your hospital?</td>
</tr>
<tr>
<td></td>
<td>Skills</td>
<td>1. Do you have policies/ protocols for offering CBT to this population? 2. If yes - Can you elaborate on the logistics (what happens)?</td>
</tr>
<tr>
<td></td>
<td>Intention/ Priority/ Plans</td>
<td>1. Are you planning to implement/ change/ enhance your Organization’s practices to offer CBT to those with a primary dx of Schizophrenia? 2. Do you have any documents/tools (and if so would you be willing to share with other Schedule I(s))?</td>
</tr>
<tr>
<td></td>
<td>Enablers</td>
<td>1. What specific to your Organization is helpful with regards to offering CBT? 2. Are there specific things that would further enable your practice?</td>
</tr>
<tr>
<td></td>
<td>Barriers</td>
<td>What specific to your Organization are the barriers (if any) with regards to offering CBT? 2. Are there specific things that would reduce those barriers?</td>
</tr>
<tr>
<td></td>
<td>Role for AGHPS</td>
<td>As a provincial organization how could the AGHPS be helpful to you? 2. Do you have suggestions on how that could be done?</td>
</tr>
<tr>
<td><strong>Topic 3: Long Acting Injectables for Schizophrenia</strong></td>
<td></td>
<td>The quality standard states Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered the option of a long-acting injectable antipsychotic medication. Do you offer LAI’s and if so, when and how in the continuum of care?</td>
</tr>
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</table>
**SECTION 2:**
Emergency Department volumes and practices

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<tr>
<th>TOPIC</th>
<th>DOMAIN</th>
<th>QUESTIONS</th>
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</thead>
</table>
| Topic 1: Discharge strategies for decreasing repeat 30 day presentations | Status | 1. Do you have specific strategies/practices aimed at decreasing repeat 30 day presentations?  
2. Do you have specific protocols for the following:  
   - “Admit no beds” or code gridlock  
   - Medical clearance  
   - Acute intoxication  
   - Psychiatrist coverage – is there 24/7 in house coverage?  
   If not what is the practice for after hours? |
| Topic 2:Protocols for “admit no bed” or code gridlock in MH | Knowledge | N/A |
| Topic 3: Protocols for medical clearance | Skills | 1. Can you elaborate on the logistics (what happens) for each of the following:  
   - “Admit no beds” or code gridlock  
   - Medical clearance  
   - Acute intoxication  
   - Psychiatrist coverage – is there 24/7 in house coverage?  
   If not what is the practice for after hours?  
Note to interviewer – combine this with Status questions |
| Topic 4: Protocols for patients with acute intoxication | Intention/ Priority/ Plans | Are you planning to implement / change/ enhance your Organization’s practices in any of these areas?  
2. Do you have any documents/tools (and if so would you be willing to share with other Schedule IIs)? |
| Topic 5: Assuming psychiatrists do not stay in house 24/7, protocols after hours | Enablers | What specific to your Organization is helpful with regards to Emergency Dept. practices for those presenting with mental health issues?  
2. Are there specific things that would further enable your practice? |
| | Barriers | What specific to your Organization are the barriers (if any) with regards to Emergency Dept. practices for those presenting with mental health issues?  
2. Are there specific things that would reduce those barriers? |
| | Role for AGHPS | As a provincial organization how could the AGHPS be helpful to you?  
Do you have suggestions on how that could be done? |
## SECTION 3:
Practices and protocols for those presenting with Dementia (without delirium)

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<th>TOPIC</th>
<th>DOMAIN</th>
<th>QUESTIONS</th>
</tr>
</thead>
</table>
| Patients with dementia being admitted to hospital. Medicine vs. psychiatry. Is this an issue? How is placement and care determined? | Status | Currently, are patients with dementia without delirium admitted to medicine or psychiatry? Are there issues with the decision of where to admit to? How is it determined (criteria)?
2. How is this managed/measured? |
| | Knowledge | Can you describe what typically happens in your hospital? |
| | Skills | 1. Do you have policies/protocols for admitting to medicine or psychiatry for this population?
2. If yes - Can you elaborate on the logistics (what happens)? |
| | Intention/Priority/Plans | Are you planning to implement/change/enhance your Organization’s admitting practices those with a dx of Dementia?
2. Do you have any documents/tools (and if so would you be willing to share with other Schedule Is)? |
| | Enablers | What specific to your Organization is helpful with regards to admitting decisions for those with Dementia?
2. Are there specific things that would further enable your practice? |
| | Barriers | What specific to your Organization are the barriers (if any) with regards to admitting practices for those with Dementia?
2. Are there specific things that would reduce those barriers? |
| | Role for AGHPS | As a provincial organization how could the AGHPS be helpful to you?

Do you have suggestions on how that could be done?
## SECTION 4:
Assisted Dying from the perspective of psychiatry

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<tr>
<th>TOPIC</th>
<th>DOMAIN</th>
<th>QUESTIONS</th>
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<tbody>
<tr>
<td>To determine the status and planning for the existing legislation on assisted dying from the perspective of psychiatry</td>
<td>Status</td>
<td>Currently, is there a formal process for those requesting assistance in dying, and if so, does it involve a psychiatrist? 2. How is this managed / measured?</td>
</tr>
<tr>
<td></td>
<td>Knowledge</td>
<td>Are you familiar with the current legislation?</td>
</tr>
<tr>
<td></td>
<td>Skills</td>
<td>Do you have policies/ protocols for assisted dying? 2. Can you elaborate on the logistics (what happens)?</td>
</tr>
<tr>
<td></td>
<td>Intention/ Priority/ Plans</td>
<td>1. Are you planning to implement / change/ enhance your Organization’s practices on assisted dying? 2. Do you have any documents/tools (and if so would you be willing to share with other Schedule 1’s)?</td>
</tr>
<tr>
<td></td>
<td>Enablers</td>
<td>What specific to your Organization is helpful with regards to a formal process for assisted dying? 2. Are there specific things that would further enable your practice?</td>
</tr>
<tr>
<td></td>
<td>Barriers</td>
<td>What specific to your Organization are the barriers (if any) with regards to a formal process for assisted dying? 2. Are there specific things that would reduce those barriers?</td>
</tr>
<tr>
<td></td>
<td>Role for AGHPS</td>
<td>As a provincial organization how could the AGHPS be helpful to you? 2. Do you have suggestions on how that could be done?</td>
</tr>
</tbody>
</table>
SECTION 5:
What are your most pressing issues?

QUESTIONS

What are your most pressing issues at this time?
Please describe / provide insight
What is the current status?
Is there a role for the AGHPS?
THE INTERVIEW PROCESS AND STRUCTURE

The following invitation was sent to every Schedule I hospital
*CHEO was excluded from the project

The AGHPS is asking for your participation in our most significant undertaking of the last several years. We are planning to interview leader(s) from Schedule I hospitals in Ontario. This could be a Chief, Director, Manager or Coordinator.

We are asking for 40 minutes of your time to participate in a telephone interview. In return we will provide you with a report that summarizes some of the systems, activities and practices in Schedule I hospitals on several high value topics (such as follow up within 7 days, CBT, ER practices, assisted dying from psychiatrist perspective).

- During this interview we will ask you about the current situation in your hospital
- We are aware that the barriers may be found at the system, regional and local level, for the purpose of this interview we want to focus on the local level
- We would like your consent to identify the name of the Organization. This will help in analyzing trends and patterns relating to region, hospital size etc. The names of those participating in the interview can remain anonymous.

Interviews with thirty eight hospitals were conducted by telephone over a nine month period. The number of leaders participating in each interview was left to the discretion of the hospital and ranged from one to six participants. A semi structured approach was utilized where the interviewee(s) were asked the same questions but the format of the responses were conversations and qualitative in nature. In order to understand, compare and contrast responses a single interviewer conducted every interview. Notes from the session were summarized immediately after the interview. There was some use of rating scales (very important to not important) in order to draw some conclusions regarding relative importance. However, this was part of an informal approach and cannot be utilized to objectively rate draw any statistical significance.

A list of participating Schedule I hospitals and their associated Local Health Integrated Network (LHIN) is included as Appendix 1.

Discussion and Findings
The following summarizes what we heard from leaders across the province. The results are not intended to report precise, objective data. Rather this should be taken as a collection of thoughts and opinions from Schedule I leaders in Ontario. It is intended to serve as a large conversation on common issues and challenges. While there is some interpretation, efforts were made to record what was stated and reduce variance in understanding through the use of a single interviewer. The findings are qualitative and the purpose of the project is to provide a deeper, more consistent understanding of what is happening in Schedule I hospitals across the province. A limitation of the project is that approximately 63% of Schedule I hospitals participated in the interviews. However, a mitigating factor is that the participating hospitals come from every LHIN and they range from large academic centres to small rural hospitals. Anecdotally it is worth noting that the responses did not appear to trend according to hospital size or LHIN.
SECTION 1: HEALTH QUALITY ONTARIO QUALITY STATEMENTS

Topic 1:

Follow up within 1 week of discharge
- 36 hospitals (95%) were aware of the benchmark. Only 2 hospitals (5%) were not aware.

- Currently, does every patient with a primary dx of Schizophrenia or Major Depression have a follow up appointment within 7 days?

  Yes: 11 (28.9%)
  No: 22 (57.9%)
  Not sure: 5 (13.2%)

How important is it for you to implement this statement compared to other priorities?
Please rate the importance of this benchmark according to the following scale

<table>
<thead>
<tr>
<th>MOST IMPORTANT</th>
<th>VERY IMPORTANT</th>
<th>IMPORTANT</th>
<th>NOT VERY IMPORTANT</th>
<th>NOT AT ALL IMPORTANT</th>
<th>NO RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 (21%)</td>
<td>22 (57.9%)</td>
<td>5 (13.2%)</td>
<td>1 (2.6%)</td>
<td>0</td>
<td>2 (5.3%)</td>
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</tbody>
</table>

Do you have formal policies addressing 7 day follow up?

Yes: 15 (39.47%)
No: 23 (60.53%)

There was some ambiguity around the wording of “formal policies.” For example, in the process of drafting some documentation and methods of monitoring, creating methodologies to meet the standard, working on pathways, using guidelines, working on phone follow up, hospital wide policies and unit specific protocols for all patients, standard discharge protocols but not specific to 2 diagnoses. Therefore we extended the positive response to include protocols, pathways etc. as proxies for formal policies.
Discussion:
The following issues were raised by those interviewed.

There is no consistent way to address, monitor, measure, or evaluate this.

- It is hard to say as we do not have a system to measure
- I don’t know if we meet the standard because there is no mechanism to measure it. We are always in crisis for beds making it difficult to achieve. Pathways are defined but not implemented. If we had an indicator we could be addressing moving towards this
- We have yet to do an analysis and that needs to be done before we can build in measurement
- The follow up appointment is included in the letter on discharge. However we have no way of knowing if the person kept the appointment
- Not 100% compliant and cannot speak with authority for schizophrenia population
- Generally yes but cannot say consistently
- I believe they do but not able to confirm that

What is “follow up”?
- If this is a patient care standard what metrics do we need to report on? We currently have several metrics that are based on old criteria and they do not measure or evaluate outcomes
- Does one follow up appointment constitute follow up? We do try to connect all patients either through the outpatient clinic(s) or if they are already connected then referring back. However many may receive a 1 time appointment but not the necessary follow up
- Would a phone call meet the standard of follow up within 7 days?

For those who said they do meet the benchmark of follow up within 7 days of discharge the following comments are noteworthy

- We have a policy that was put into place about 2 years ago that every discharged patient will receive a call from a nurse for follow up between 48 hours and 7 days after discharge
- For a diagnosis of schizophrenia 100% have a scheduled appointment within 7 days. If they are already connected to a psychiatrist or family physician we book an appointment for them within 7 days. Our ACT Team provides a brief intense management holding team (social worker, nurse, recreation and psychiatrist). If the patient is not connected with anyone we will follow them. They are seen while inpatient and then followed after discharge. Therefore we have put a team in place to make sure seen within 7 days
- We do it as part of the clinical pathway
- We have put together an algorithm for every inpatient. We obtain their discharge appointment before they leave. If they are an “orphan” patient (no family physician) we make the request with Health Care Connect – so they are put on the roster to get a family physician. We see them within the 7 days in outpatient dept
- Every patient is offered an appointment within 24-48 hours post discharge. They may decline but the appointment is offered. It is with a clinician in the community – not a psychiatrist. Our Chief of Staff supports this for all patients, including those with a diagnosis of schizophrenia
- We have implemented changes in order to do this. The need for 7 day follow up and the 30 day repeat issue caused us to address these things. We moved resources and allocated one person to do this. They do a follow up appointment with every patient either in person or by phone. The patient is given an appointment that works for them. We check on whether they have medication questions, how they are managing and whether they have follow up arranged. If they are not OK “we scoop them up” there

For those who said they do not meet the benchmark of follow up within 7 days of discharge the following comments are noteworthy

- Not all patients. It depends on need and willingness. They are often on a Form 1. When they are discharged from nonvoluntary to voluntary status they may not want the follow up
- For diagnosis of major depression. We have limited resources and we do not have an outpatient department (OPD). OPD in other hospitals have long waiting lists. If there is a primary provider we will make the appointment within 7 days, assuming the patient is willing. However, physicians are booked well in advance and it can be a struggle to get the appointment. We do try to get the appointment for them before
discharge. If they are not connected with any healthcare provider we try to link them with someone. Our success with this fluctuates. If the team is concerned with the condition of a particular patient and how the follow up might be crucial the psychiatrist from the inpatient unit will see them within 7 days for a limited follow up visit. However, some psychiatrists do not do this as it is seen as outside their role. Therefore, the ultimate result is a bit “hit or miss.” A large number of patients come from the northern communities. We are working with these communities – having conversations now to explore ways to address this.

- We are targeting for all patients regardless of diagnosis to have follow up within 7 days. However, we are currently closer to 2 weeks. It is part of our Quality Improvement Standards and we are actively working on it.
- If the patient has no previous connection to a psychiatrist in this area it is challenging to meet that timeframe. It might be 2 weeks. We have 6 psychiatrists working here in the outpatient department (they also cover inpatient) and waiting lists are 10 months. Therein lies the challenge for this benchmark. However, patients with a primary diagnosis of schizophrenia typically are seen within 7 days through a variety of options (early psychosis intervention – EPI, ACT, outpatient psychiatrist etc). We estimate 95% are seen within 7 days.
- Overwhelmingly follow up goes to our mobile team. They stay connected in the community for about 6 weeks/42 days (there is some flexibility). This has the quickest pick up.
- Typically this is managed on an individualized basis as there are varying mechanisms for follow up. We have a short term follow up outpatient clinic for 2–3 visits. Some patients have existing supports in the community that they return to unless they need more intensive follow up. Information is sent to family physicians including discharge summary from the team and medication details. Patients have a variety of places for follow up. However if they are coming to us for follow up they can expect to be seen (often by the same psychiatrist as inpatient) in 7–14 days. Although we cannot say we meet the standard completely we do well in looking after the follow up of patients upon discharge, typically within 7–14 days. Some patients with a diagnosis of major depression are followed up by psychiatry after discharge. However, they go back to the family physician. Our local family physicians are good about timely follow up if we provide the information to them. For those with a diagnosis of schizophrenia we are trying to address their longer term needs (chronic, long term). We do the short term follow up well. However, we struggle in this region to have the long term needs addressed in the community (related to under funding and under resourcing). We have recently been working with FACT team – full service. This will help especially if there is an expansion of FACT teams.
- Currently this is a struggle for us. Inpatients that are discharged to day programs are generally seen within 7 days. However, for those who are simply discharged we have a low % of being seen within 7 days.
- Our focus for this is on schizophrenia rather than depression due to capacity. The real drivers are more around risk (e.g. suicidal ideation).
- This is one of our indicators on the balanced scorecard. We have been monitoring and finding actions to continuously improve. It is reviewed monthly by our senior team with the Director of Outpatients as the lead. We do an analysis of every case. We are currently at about 79–80% seen within 7 days. The remaining 20% may have been readmitted to another Schedule I, not attended an appointment, not available for the appointment or involuntary patients that did not want help and continue to not want follow up.
After discharge it can be beyond the control of the Schedule 1
• For CMHA case managers the wait list is more than 7 days. The actual availability of support outside the Schedule 1 is a major contributor. Wait lists for CMHA of 1-3 weeks.
• If referred to outpatient crisis program they will be seen by a psychiatrist within 72 hours.
• Most patients with schizophrenia do not return after 72 hours. We look at what is appropriate for follow up regardless of diagnosis.
• Most patients with schizophrenia do not have access to community support to pick up these patients. We need to accommodate the need. The hospital does not have an outpatient department. It has inpatients and an ACT team for outpatients.
• Northwestern Ontario – there are 30,000 people without a family physician in a population of 100,000. Psychiatry and hospital outpatient services can have lengthy waits.
• We are actively pursuing ways to address this issue. Part of the gap relates to patient ambivalence - in circumstances of homelessness or near homeless they are not likely to keep the follow up visit.
• They can be referred to our mental health outpatient department. They can go back to an existing psychiatrist. We can refer to an outpatient psychiatrist. These last 2 can be a bridge to outside agencies - group program(s).
A variety of approaches:
• We have just completed a 6 month audit on the major depression quality statement.
• We don’t meet the benchmark. We are more likely to meet the benchmark for schizophrenia although at times we can’t even meet that benchmark. We have also noted that although there is an appointment, we do not have a mechanism for ensuring the follow through.
• There are a broad set of responses because there are varying circumstances. For example, is there existing support? Is this a new diagnosis with medications prescribed or a known diagnosis already on medication? Therefore, it is not a "black or white" answer. However, discharge follow up with recent medication changes might have a different path. We have a large catchment area and persons may be discharged back to their own catchment area. Transportation can also be challenging.
• Not everyone needs our follow up and they are referred back to family physicians or community – i.e. existing care. We don’t control the time to follow up there.
• If the patient is being followed up by our psychiatrists they will be referred to outpatient services for an appointment (typically in 3-4 months). However, we have an urgent care walk in service that the patient is told about. It operates 5 days a week.
• If they have an existing provider they will be referred back to them (family physician or community care). If they are from outside our catchment area they go back to that community. They can get a referral for our psychiatrist from their family physician PRN.
• No. 25% of our inpatients are homeless and have no primary care provider. We connect them with a health provider – family health teams are very helpful. There are about 75 physicians that we can access.

There are examples of innovative ways to attempt to meet the 7 day follow up target.
• We are taking the lead on a new drop in bridging service serving 4 populations.
• A discharge planner on the inpatient unit works on scheduling this with our outpatient teams or beyond with family physicians.
• We are looking at revamping our outpatient services to become less medically (psychiatrist) dependent, and increasing the use of other professional disciplines to improve access and decrease wait times.

Conclusion: 95% of hospitals were aware of this benchmark. A high degree of importance is placed on follow up within 7 days of discharge (78.9% rated most or very important). However only 28.9% of hospitals are currently in compliance with the benchmark. During the interviews it was evident that significant effort and consideration is being undertaken by Schedule 1 hospitals to attempt to meet the standard. There are examples of innovative approaches to address the issue. Some challenges and barriers are worth noting. There is not a clear definition or understanding of “follow up” Is this merely some form of contact or is there a more therapeutic requisite? While feeling responsible for ensuring the follow up, Schedule 1 hospitals can also feel it is beyond their control in many cases. This constraint is difficult to reconcile. How can we insist on compliance in those situations? Finally, we are struck by the total lack of consistency among Schedule 1 operations. While some differences are expected due to the size of the province and the varying environments, there is almost no “common ground” related to intake and discharge back to the community. This will be noted throughout the report as it was an underlying theme.
**SECTION 1: HEALTH QUALITY ONTARIO QUALITY STATEMENTS**

**Topic 2**

**Individual Cognitive Behaviour Therapy (CBT) for those with a primary diagnosis of Schizophrenia.**

37 hospitals responded to the questions on CBT.

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**Discussion**

Although the rating was fairly "scattered" there was a high level of homogeneity in the discussions. Three issues were brought forward by respondents.

**Resources**

- To truly offer this individually would create years of wait lists under the current situation.
- Those resources don’t exist anywhere.

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**How important is it for you to implement this statement compared to other priorities?**

Please rate the importance of this benchmark according to the following scale:

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<tr>
<th>MOST IMPORTANT</th>
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<th>IMPORTANT</th>
<th>NOT VERY IMPORTANT</th>
<th>NOT AT ALL IMPORTANT</th>
<th>NO RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (8.11%)</td>
<td>8 (21.62%)</td>
<td>17 (45.95)</td>
<td>9 (24.32%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
</tbody>
</table>

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1. Were you aware of this benchmark?
   - 35 (94.6%) said yes
   - 2 (5.4%) said no

2. Currently, is every patient with a primary dx of Schizophrenia offered individual cognitive behavioural therapy?
   - 3 (8.11%) said yes
   - 34 (91.89%) said no

Do you have formal policies/protocols for offering CBT to this population?
- Yes 2 (5.41%)
- No 35 (94.59%)

Is this measured or evaluated?
- Yes 3 (8.11%)
- No 34 (91.89%)

For those responding "yes" two hospitals utilized evaluations forms and in one hospital it was a discussion on daily rounds.

Are you planning to implement changes or enhancements to your Organization’s practices to meet a benchmark of individual CBT for those with a primary dx of Schizophrenia?
- Yes 13 (35.14%)
- No 24 (64.86%)

Those planning changes or enhancements either described a vague, preliminary intention or some description of staff educational initiative regarding CBT.

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- I cannot even imagine how we could achieve this with current circumstances.
- Providing this within current budgets is a significant challenge.
- Even if the staff have the training there needs to be sufficient time built in to do individual CBT.
- For inpatients we are always over capacity.
- Resource becomes an issue. We are looking to see who else we can train given that all our staff are so busy that it is tough to offer this.
- It is mandated and therefore we will look at implementing this. However, it is so resource intense and we do not have the human resources right now. A lot to prepare. The challenge is to meet the increasing volumes and demands while moving from groups to individuals.

**Standards**

There is no consistent interpretation of clinical competence in CBT for psychosis (education, monitoring & supervision; quality measures).

- A significant barrier is education and training of staff who right now do not have training and experience in CBT for psychosis.
- The scope of an initiative to educate, mentor and supervise staff to have sufficient access to CBT for psychosis is large and expensive.
- What is the hospital’s role and / or capacity in providing sufficient training and expertise oversight for CBT for psychosis?
Currently hospitals and in some cases LHINs are proceeding to educate/train staff in CBT for psychosis to work towards compliance with this benchmark/standard. This training appears to vary from 4 hour sessions, to 2 day sessions. If we are to achieve a consistent standard what does the training for that look like? Should there be a course design for this?

Appropriateness

The level of acuity for inpatients in Schedule I hospitals was raised several times. Example response: For inpatients the level of acuity and the short length of stay (5-10 days) make CBT for every patient with schizophrenia inappropriate. We stabilize and discharge with follow up plans due to the pressure for beds.

There was wide agreement that this benchmark/standard is not aligned with the level of acuity and the inpatient component should be revisited or revised to reflect the different stages of recovery for inpatients. This should be considered on an individual basis and perhaps “set the stage” for CBT when it becomes appropriate.

Not all respondents were clear or convinced that this is the best practice for every person with a primary diagnosis of Schizophrenia. Example response: What is clinically understood about this modality? It is not necessarily the best option across the board. In the literature the clinical responsiveness to that intervention is mismatched. Do not support an approach that offers it to all patients across the board.

Conclusion:

Among respondents there is no consensus that best practice is individual CBT for patients with a primary diagnosis of Schizophrenia and there is a real concern that the level of acuity of Schedule I inpatients is not being acknowledged.

The overwhelming concerns were a critical lack of resources and insufficient groundwork establishing education, standards and quality measurements for delivering this professional service. What is sufficient training and oversight? How will we fund that level of education? Once the training has been achieved how will we find sufficient time to do individual CBT when it competes with issues such as capacity and access to beds etc. There was a consistent message among leaders surveyed that this will be very difficult to achieve and may not always reflect the needs of the patient given acuity and lengths of stay.

Despite the range allocated to level of importance, there appears to be a real effort on the part of Schedule I hospitals to work towards complying with this mandate. Of those who express an intention to make changes there was a dichotomy. Several gave a vague intention to make changes in order to comply. Others described some level of training or education in CBT. In all cases there is a clear need for more direction, funding and standardization to avoid a scattered and fragmented approach to a very large challenge.

SECTION 1: HEALTH QUALITY ONTARIO
QUALITY STATEMENTS

Topic 3

Utilization and Access to long acting injectable (LAI)

Adults who are admitted to an inpatient setting with a primary diagnosis of schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

Discussion

- Long acting injectable antipsychotic medications (LAIs) were offered in all 38 hospitals surveyed.
- Access to LAIs is generally well developed with administration channels prevalent in inpatient units, outpatient clinics, ACT teams, community, and family physicians. There was no respondent that indicated patients would not be able to access LAIs if prescribed.

Comments that Describe Ease of Access

- Started on inpatient unit; quick follow up and close monitoring in outpatient clinic.
- Drop in clinic 24/7 for patient’s convenience.
- A large outpatient clinic.
- All staff trained to administer LAI. Will go to patient’s home.
- Trying to work towards a shared care model with the community for LAI administration.
- We provide education, manage issues, monitor B/P, side effects. It is broader than LAIs. It is about health and wellness.

Although there were no examples where LAIs were not prescribed due to difficulties with access to administration, there were several comments worth noting that indicate some barriers.

Comments on Barriers to Access

- Prescribing depends on the psychiatrist’s relationship with health care providers. There
needs to be a reliable option for follow up after discharge. Not always the case
• When an LAI is in place over an extended period of time and there are no other issues
the patient could be taken over by a family physician. However they are not all
comfortable with this. Apprehension about taking it over results in clinics getting bigger
• There can be a cost issue. If there are no benefits we refer to a social worker. We can
access a small fund to bridge until benefits are received
• Volumes are increasing – becoming overwhelming for the nurse responsible for LAI
injection
• No mechanism to measure this
• Our biggest challenge is administration of LAIs since ACT team rejects patients over 65
years old. Geriatric outreach is very different than ACT
• This issue comes up once a year at budget time. Expensive and not covered for inpatients
Covered for outpatients. However, concern over discharging just so it can be covered. No
observation after initial injection. We want to start as an inpatient to make sure they are ok

The primary determinant on the decision to prescribe an LAI is individual psychiatrist
practice decision. Although there was some reference to including the decision as part of
a clinical care pathway (2 references), in all cases the decision rests with the individual
psychiatrist. However, two trends emerged
(1) There is an apparent tendency to
consider LAIs as an alternative rather than a
first option and
(2) there are clear “cultural”
baises that appear to influence the decision
within departments of psychiatry in these
hospitals

Comments that suggest the use of LAI’s as an
alternative rather than a first option:
• This is a first or second line treatment related to
compilation and dependent upon patient
williness
• Some patients are not interested at first
(needle) but are sometimes more receptive
later
• Decision factors include number of
admissions, compliance
• This is highly dependent on the psychiatrist
However, generally seems to still be related to
failed compliance with medications. However,
since the quality standard there has been a
lot of discussion about this and whether it is
appropriate to use this as a last resort option.
We do have LAI clinics twice a week (day and
evening) so we are set up for it
• Not offered as a first line but can become an
option
• Highly dependent on the psychiatrist and
generally related to failed compliance
• There is no clear path to prescribing
However, it seems related to failed medication
compliance
• Offered but not front line. Related to
number of presentations to ER, readmissions
and length of stays being extended
• LAIs are not always treatment of choice
Compliance not always an issue and we might
start treatment with a short acting medication.
There is not a formalized policy for LAIs and
no standard approach. Generally stabilize on
short acting and once stable convert to an LAI
as much as possible

Comments that support the perception of
“cultural” differences among hospitals
• We are big fans of LAIs and have been for
more than 20 years. Was emphasized during
education at Dalhousie and we promote it as
an effective option
• As a group our psychiatrists actively promote
culture of using LAIs especially if there is an
issue of noncompliance. However we do use it
as a first line treatment
• We have two psychiatrists that have
extensive background and understanding of
LAIs. We are very aware and pro LAI
• LAI is offered as soon as medication
prescribed. We do a good job with this
• We have reviewed the literature and the
evidence. All our psychiatrists have met and
discussed this and endorsed the use of LAI’s
I am confident that we do offer this to every
patient with a primary diagnosis of schizop-
phrenia. We have one of the largest LAI clinics
anywhere

Comments on emerging changes in practice
• It is offered. However, the literature is
suggesting earlier in the process and we have
not consistently made that change in practice.
It used to be thought of as a last resort for
poor adherence or poor symptom manage-
ment with other methods. It is challenging to
influence the change. We have had psychia-
trists from other Organizations present this in
grand rounds. Will continue to work on educa-
tion and look for gradual change in practice/
behaviour. The role of the Chief can be
important here and we are looking for a Chief
now
• What we are doing with care pathways aligns
with this standard – we have a pathway for
psychosis / schizophrenia. Every patient will fall
into a care pathway – clear guidelines regard-
ing the conditions under which LAIs are offered
with triggers and prompts.
**Conclusion:**
LAIs are offered in every Schedule I hospital, but there are significant variances in why and when. While some hospitals and hospital psychiatrists prescribe this as a first-line treatment, it is more prevalent to be prescribed later on in the care journey based on a variety of drivers including:
- Compliance with medication
- Number of presentations to ER, readmissions, impact on lengths of stay
- Patient willingness and accessibility to funding (benefits)
- “Cultural” approaches within groups of psychiatrists – comfort, prior experience, champions

While access to administration of LAIs appears to be well developed, there are some indications that volumes are, or will, increase given the progression of standards and evidence supporting the efficacy of LAIs. We do not appear to have a systematic mechanism to measure and evaluate the impact of potential increasing volumes for long acting injectables. There is some initial indication of emerging stress on current established distribution channels. One respondent suggested that the discussions around longer acting injectables (2-3 months) may mitigate some impending volume issues. This is unclear and, given our inability to measure and evaluate, is destined to follow a course of anecdotal evidence and individual perceptions. Neither of these approaches have, to date, been helpful to Schedule I hospitals in strategic planning based on evidence.

Do you have specific strategies/practices/protocols aimed at decreasing repeat 30 day presentations?

Yes 33 (94.29%)
No 2 (5.71%)
N/A 3 – no Emergency Dept

Of the 33 hospitals that indicated they had strategies in place to address this:
- Strategies at the hospital level 16 (48.49%)
- Strategies at the LHIN or regional level 7 (21.21%)
- Strategies at both levels 10 (30.30%)

23 hospitals indicate measuring or evaluating 30 day strategies but there are no apparent consistent metrics or methodologies. Three hospitals referred to a “scorecard”

**Discussion:**
- There were many examples of significant time, effort and resources placed on this issue
- There were also examples of innovative approaches, some with apparent success
- There was no consistent approach and no obvious common trends. It appears that unique strategies to a common issue are being developed at either the hospital level, the LHIN level or both

**Conclusion:**
With the strategies being developed at the LHIN level we are seeing a shift to a more systematic approach. Is there a collective opportunity for Schedule I leaders to weave together the LHIN initiatives and effective hospital initiatives to design a broad approach? This could reflect the potential of creating collaborative projects and/or methodologies while acknowledging the uniqueness of each hospital.

A final cautionary observation articulated by one survey participant. Presenting to the hospital again means that they know there is a place to go where they can get the needed support right away. (e.g. 18 year old with suicidal thoughts) We should be careful not to skew this entirely as a negative thing. The Emergency Dept is part of the Mental Health team. We would rather they come in to here than not seek any help (nothing else is available at night)

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**SECTION 2 EMERGENCY SYSTEMS**

Emergency Department (ED) volumes and practices for patients presenting with mental health issues are significant drivers of system access and care for Schedule I hospitals. We therefore asked some questions that link the care of mentally ill patients to practices in the ED.

**Topic 1**

Discharge strategies for decreasing repeat 30 day presentations
SECTION 2 EMERGENCY SYSTEMS

Topic 2

Protocols for “admit no bed” or code gridlock in MH

32 of the 38 hospitals (84.21%) have indicated this is a major challenge

Discussion:
There are several themes that emerged describing how this challenge is managed

These include
• Negotiation and prioritizing is central to managing
• LHIN level strategies such as bed registries / Critical
• Surge: There are some increases in bed numbers – surge beds. The numbers in each hospital vary but are typically small (1-3) and often are not associated with any additional staffing

As compared to other topics in the Emergency Systems section, there appears to be a more formal or structured approach to address volumes and capacity and more consistencies in the language describing the norms and protocols. The centrepiice in virtually all cases is a process of systematized situation assessment, determining the level of need for the individual, negotiating internally and among other hospitals on how to most effectively utilize the scarce resource – essentially a competition among patients, a lottery for a bed, except that a lottery is random and a very diligent and experienced group of professionals is determining the winner.

The level of urgency, and the degree of the struggle in many hospitals is evident in the responses to this question. The following is a list of language used by survey participants in the conversation on this issue
• An everyday struggle
• Desperate because the need is so great
• Have never seen these volumes before
• This is our situation every day with average capacity 115%. We have managed to reduce it to 105%
• Who needs the next bed the most? People on a Form 1 in other outlying hospitals are waiting for us. Every morning our coordinator assesses the most urgent of those and how to keep people safe while waiting
• A lot of creativity

Conclusion:
Although there appears to be more structure and consistency in addressing the challenges of volumes and capacity, this is a system wide problem with solutions primarily being constructed at the hospital and LHIN levels. While that may gain some traction in “keeping a lid” on our inability to meet the needs of those presenting to Schedule I hospitals, it may also be masking a simmering “near crisis” level province wide. It raises the question as to whether the dedication, diligence and expertise of those managing the challenge are not creating a “finger in the dam” situation that is not rectifying the underlying challenge.

Have to manage somehow
• Volumes and acuity seem higher than ever
• At times we beg outside our LHIN
• We use single rooms as double rooms
SECTION 2 EMERGENCY SYSTEMS

Topic 3

Protocols for medical clearance

In 94.28% of 35 hospitals responding to this question, it is the Emergency physician who determines medical stability. In an additional 2 hospitals (5.71%) it appeared that the ED physician was responsible but it was not entirely clear. It appears that there is a very consistent practice across Ontario that confers the responsibility for determining medical clearance to the Emergency Department physician.

Discussion:
There is a trend to change the language from Medical Clearance to Medical Stability and the AHGPS supports changing the terminology to Medical Stability.

There are varying degrees of concern and contention within the ER of Schedule I hospitals in determining medical stability for those presenting with mental health and addiction issues.

There is no uniform practice relating to policies, protocols, assessment tools or other formalized standards. In fact there are examples of failed attempts to formalize internal practices as described in the following examples from respondents:

- Tried generic approach but not supported
- Tried standards but no consensus like in other countries / jurisdictions
- No standards Trying to develop common principles
- Ambiguous – what does medical clearance mean?
- What is medically safe vs. medically clear

Despite this there seems to be clear progress in some hospitals and among some LHINs in formalizing standards for medical stability. There are several initiatives underway across the province and a noticeable shift in finding solutions.

Conclusion:
Accurately determining medical stability for those presenting with mental illness and / or addictions is vitally important in order to avoid the risk of missing a medical emergency because it has been masked by the stigma associated with mental illness. It is therefore in the best interest of both Emergency and Psychiatry to collaborate on a resolution. There have been attempts through professional organizations, LHINs and hospitals to address this. Given the number of hospital and LHIN level pilots and initiatives currently underway, is there an opportunity to bring those experiences together and assemble a provincial table to review, analyse and consider the local and regional efforts in order to craft a provincial framework?
SECTION 2 EMERGENCY SYSTEMS

Topic 4

Protocols for patients with acute intoxication

Although this was addressed as a separate topic, it might be helpful to include protocols for those with acute intoxication together with protocols for determining medical stability.

Discussion:
We note a trend utilizing the Clinical Institute Withdrawal Assessment Score (CIWA) This was mentioned specifically by 12 hospital participants. That may be an underrepresentation as we did not include a specific question on this. Similar to some other topics there appears to be a strong individual approach to address the issues. Respondents described:
- Opioid withdrawal protocol
- An ER specific protocol
- Developed definitions
- An order set
- Working on a care path
- Criteria of less than 18 and history of seizures
- Regional RAI data triggers CAPs for substance abuse.

Also, again there seems to be varying access to resources. Some hospitals have access to detoxification service. Rapid Access Addictions Medicine (RAAM), withdrawal centre and others do not have those supports available to them. This implies a different standard of care depending on your hospital or geography.

It is worth noting a perceived tendency in the interviews to depict an increase in addictions, specifically opioids. Once comment is mentioned here as an example of a cautionary observation. As a mental health system we are not prepared for the opioid presentations. We are overwhelmed with the volumes that have exploded. There is a gap in the medical management. We are talking about naloxone but once they arrive and go to inpatients the psychopharmaceutical and psychosocial issues are profound. The level of violence is like nothing else we have seen and we don’t have psychomedications to deal with the profound psychosis that is quite different from others. As a system we need practice standards for this. How we medically manage this is not the same as other things.

Conclusion:
There is some overlap between protocols for acute intoxication and protocols for medical stability. There may be some advantage in combining aspects of both for the purpose of planning. Again we are struck by the variance in resources available to support the Schedule I Emergency Departments in caring for this group of patients. Is there a minimum standard that one should expect regardless of hospital or geography when presenting to a Schedule I Emergency Department? Can we assemble some of the work being undertaken by hospitals and LHINs to, at minimum, provide information to the province?

SECTION 2 EMERGENCY SYSTEMS

Topic 5

Protocols for psychiatry coverage 24/7

We asked the question – Assuming psychiatrists do not stay in house 24/7, what is the protocol for “after hours”?

Discussion:
There was a consistent profile relating to 24/7 access to psychiatrist in a Schedule I hospital
- All hospitals acknowledge a mandate of 24/7 access to psychiatry because of Schedule I status
- Almost no Schedule I has a psychiatrist in house at all times
- The exceptions are (1) large academic hospitals, although the coverage is often by a resident and (2) in one case where the on call psychiatrist must stay on the premises if they live outside a geographical region
- In all other cases there is an on-call system with a named psychiatrist or physician with psychiatric training 24/7
While this is accurate it can be misleading. The coverage for nights and weekends is often managed by cobbling together existing resources. These include physicians hired as locums or hospitalists, residents and for the most part crisis workers/crisis teams. These clinicians appear to act as (1) frontline for those presenting with mental health issues and (2) as a buffer to determine when a psychiatrist should be consulted.

• We heard that in some hospitals there is a reluctance to consult psychiatrists at night because there are so few and they are on call so often that it creates a situation of using scarce resources to best advantage.
• Regardless of the reason, there is, in some hospitals, a discrepancy between the policy and the norm. However, this system appears to work well although it can result in delays in decision making until morning.

Conclusion:
This is a durable challenge since it is not likely going to change with a standard or mandated policy. There will continue to be “workarounds” until the underlying cause(s) are addressed. This may include recruitment and retention of psychiatrists – a very challenging issue. While we did hear about perceived delays in treatment decisions, we did not hear of any significant negative outcome. This does not mean it does not exist, but it perhaps speaks to the extent to which crisis teams and other experienced clinical staff intervene and the value of their clinical skill and experience. While increasing the number of psychiatrists available 24/7 might be unrealistic, we appear to have a somewhat informal system that is effective and efficient. Is there an opportunity to acknowledge, support and augment the role of these professionals? By shining a lens on what is currently the professional practice we might find creative solutions.

**SECTION 3: PRACTICES AND PROTOCOLS FOR PATIENTS ADMITTED WITH DEMENTIA (WITHOUT DELIRIUM)**

There are several components to understanding this complex issue. We hear about the challenges generally. However, the interviews were helpful in breaking down the large overview into a few categories including admission decisions, behavioural challenges, access to specialized support, optimal environment and access to long term care.

**Discussion**
Admission from the ER. Some hospitals described this as a major issue creating significant challenges and tension. Other hospitals state they have no issue or tension surrounding the admission and management of care for patients with dementia without delirium. Many responders were somewhere in the middle. For the most part formal policies were not in place regardless of the level of discord, although there was some use of exclusion criteria. Also, there was very little mention of formal measurement or evaluation over time. Interestingly, the explanation of admission and care practices did not appear to differ based upon the relationships and tensions. Overall the practice appears to be somewhat consistent. Patients are cared for by Medicine unless there are significant behavioural challenges in which case psychiatry/mental health beds may be the preferred option. This scenario is in recognition that mental health beds in Schedule I hospitals are set up for acute psychotic incidents rather than chronic dementia. Mental health staff, however, may have special expertise in managing behavioural challenges. In fact, we found that the principal driver for decisions around admission and care plan was not policies nor relationships, but the extent of behavioural involvement.

Access to specialized support. There appears to be an uneven distribution of supportive resources available to Schedule I hospitals throughout the province. Hospitals that stated there were no tensions or significant challenges often had access to specialized care for patients with dementia. This included a behavioural unit with dedicated beds, a memory care unit, a dementia unit, and an MOU with another Organization. For many other hospitals there was little to no collateral support. Beyond impacting capacity which will be discussed separately it was brought to our attention that the environmental needs of patients with chronic dementia are very different than those found on units established for patients with acute psychosis. We have an apparent approach that is care by bed circumstance rather than case based on patient need. As a province we need to offer a better system to those with chronic dementia.
Conclusion:
Collegial relationships, while likely to have an impact on the satisfaction of professionals is not an apparent driver of decisions regarding admission and care by Medicine vs Psychiatry. From our interviews the single biggest driver in deciding where and how to care for the patient with chronic dementia is behaviour. While Medicine appears to be the core provider of care, significant behavioural challenges can sway the decision to psychiatry/mental health unit for access to expertise in managing behaviour. It was evident through the discussions that there is notable uneven access to specialized support and care. Some hospitals can look to units that have been designed and staffed to provide quality care to those with chronic dementia. However, many hospitals have no collateral support and must provide care in an environment that is not suitable to their needs and a mandate that focuses on acute psychotic episodes. While we recognize the systemic challenge in accessing long term care, we were surprised to hear from several respondents the reluctance to accept patients from Mental Health as a perceived direct result of stigma. When determining long term placement we heard about arbitrary decisions with little to no criteria, accountability or oversight. While this is anecdotal and perception, the source is leaders in Schedule I hospitals and is at the very least a disturbing possibility.

We do not have a clear answer but it is one of the biggest challenges for the whole hospital.

SECTION 4 ASSISTED DYING FROM PERSPECTIVE OF PSYCHIATRY

In this section we asked questions to determine the status and planning for the existing legislation on assisted dying from the perspective of psychiatry.

Currently, is there a formal process for those requesting assistance in dying, and if so does it involve a psychiatrist? 34 of the 38 hospitals interviewed did have a formal process. 3 Catholic hospitals did not have a formal process to refer to another organization. 1 N/A - out of scope.

Psychiatrists were generally (approximately 65%) involved in the process to consult as needed. There were only two examples of psychiatry consulting with every patient.

Conclusion:
There appears to be established formal processes in place for medical assistance in dying (MAID) throughout the province. Psychiatrists are involved to varying degrees. It is generally the practice to consult psychiatry on a referral basis as indicated. Overall, there are no apparent concerns relating specifically to the role of psychiatry. This section was intended to give a baseline on the status of the current legislation. We are satisfied that we have done that.
Summary of Findings
Throughout the report we have arrived at conclusions to specific topics including
- Follow up within 1 week of discharge
- Individual Cognitive Behaviour Therapy (CBT) for those with a primary diagnosis of Schizophrenia
- Utilization and Access to long acting injectable (LAI)
- Practices and Protocols for Patients Admitted with Dementia (without delirium)
- Discharge strategies for decreasing repeat 30 day presentations
- Protocols for “admits no bed” or code gridlock in MH
- Protocols for medical clearance
- Protocols for patients with acute intoxication
- Protocols for psychiatry coverage 24/7
- Assisted Dying from Perspective of Psychiatry

The conclusions from the specific questions are important and offer the opportunity to address distinctive actions and recommendations and we invite the reader to refer to the conclusions in each section of the report for the specific findings on those topics.

Here we will share our findings on the whole as opposed to the parts. Our process of interviewing leaders from 38 Schedule I hospitals provided important insight into the state of the provision of mental health care in general hospitals in Ontario.

We concluded each of the interviews with an open ended question asking the participants to identify their most pressing issues. We encouraged a dialogue in order to gain a reasonable understanding of those pressing issues. While there were a few issues that were expressed by a single hospital, for the most part the answers clustered into 3 major categories:

I. Access, Capacity, Volumes, SURGE
II. Violence and Security
III. The Lack of a System for Mental Health

The categories relating to volumes and pressure for beds, and the profound concern for safety and security of patients and staff are significant and there needs to be real follow up to address those concerns. However, it becomes apparent that these are two overwhelming symptoms of an absolute absence of a mental health care system.

The most striking conclusion of our interviews with Schedule I leaders was the extent to which the lack of a system for mental healthcare is having an impact on virtually every aspect of their work. We can see this woven through the responses to each of the questions in this document. We found an appalling portrait of stellar professionals going to great lengths to meet the needs of those with serious mental illness in a random, disconnected environment.

The role and mandate for Schedule I hospitals in not clear. The specialized and community support available varies immensely from hospital to hospital. There are almost no provincial standards, best practices, processes or tools. As a result each hospital is attempting to resolve complex problems on their own. There is some clear movement towards a LHIN level approach. This appears to be a grassroots effort based on an inherent desire for some sort of systemized approach. Given the homogeneity of the challenges there would seem to be an opportunity for a more collective system to address them. For example, while a single hospital or LHIN may develop strategies for volumes and wait lists, it would be logical to assemble those strategies into a collective provincial framework. Beyond those strategies how can we even begin to address the underlying causes for the difficulty in access and capacity without a system to do that?

We congratulate Health Quality Ontario’s work on standards and recognize that they present a real opportunity to reach for benchmarks and best practices. However, the follow through to meet the benchmarks is then left to each hospital to implement. Leaders are deciding how to reallocate resources, change internal systems and come up with an attempt to comply. We heard that these benchmarks are seen as very important, but generally unachievable. We also acknowledge and congratulate the level of commitment and diligence we found among hospital leaders to find ways to comply.

If we, as a province, believe that follow up with 7 days of discharge is a standard that all Ontario residents should expect, then how do we, as a province, “get behind” that commitment? How do we define what is meant by follow up, how do the numbers line up to resource that service? What best practices are out there to learn from, and how do we measure and evaluate our progress and outcomes?

If we, as a province, are committed to
individual CBT for those with a primary diagnosis of Schizophrenia, how do we blanket the province with an established educational curriculum and the resources to implement and evaluate the results of such a huge undertaking? Or will we ask each hospital or LHIN to figure it out and put something in place to say we are complying with a benchmark we have not really committed to.

Are we satisfied to ignore what Schedule I leaders are telling us when they say that the level of violence, not the treatment of illness, is the bigger challenge?

There are examples of system excellence in Ontario for those with a diagnosis of cancer or a cardiac illness. There is no equivalent system for those with mental illness and the lack of such a system is being played out in problems in Emergency Departments and Schedule I hospitals in every corner of the province. We believe that there is real opportunity to "connect the dots" into a coordinated system of care for those with serious mental illness. Health Quality Ontario has started to craft a system at the level of a vision for standards. There is an emerging, natural shift to a LHIN level approach. The LHIN structure provides a mechanism whereby we can weave together a provincial level system. It can allow us to assemble tables of expert leaders to develop the ideas, the processes, and the creative solutions. There is a remarkable willingness and dedication within Ontario Schedule I hospitals to provide excellent care and service to our citizens. The AGHIPS, as a provincial organization, is positioned and devoted to the concept of developing a true system for mental healthcare.

We understand that it is time to take the groundwork done by the HQO to the operational level. What do we need to implement standards and best practices? How can we pull together the outstanding strategies that were described to us in hospitals and LHINS, take the existing examples of Ontario models for cancer and cardiac illness, and begin to establish a provincial system for mental healthcare?

The purpose of conducting this Environmental Scan was to determine what challenges and strategies leaders in Schedule I hospitals face. We found many important specific issues that must be confronted, such as capacity and violence. The AGHIPS will use that specific information to assist and advocate for Schedule I hospitals. However, what we learned, and what will guide our priorities, is that we are steering a system where there is no system to steer. We will devote our efforts to collaborating with stakeholders to find a path to a system we can all be proud of.

Acknowledgements
The AGHIPS wishes to thank the participating hospitals and leaders for their time and insight. We also thank the Mental Health and Addictions Acute Care Alliance for their assistance in promoting the project, and Health Quality Ontario for their inclusive approach in developing quality statements.
Appendix 1: Participating hospitals
Total interviews: 38 of 60
(63% of invited hospitals)

**ERIE ST. CLAIR LHIN**
Hotel Dieu Grace Hospital

**SOUTHWEST LHIN**
Grey Bruce Health Services
Huron Perth Healthcare Alliance
London Health Sciences Centre
Woodstock General Hospital

**WATERLOO WELLINGTON LHIN**
Grand River Hospital

**HAMILTON NIAGARA HALDIMAND BRANT LHIN**
Brantford General Hospital
Joseph Brant Memorial Hospital
Niagara Health System

**CENTRAL WEST**
William Osier Health Centre

**MISSISSAUGA HALTON LHIN**
Halton Healthcare Services

**TORONTO CENTRAL LHIN**
Baycrest Hospital
CAMH
St Michael’s Hospital
Sunnybrook Health Sciences Centre
Toronto East General Hospital (Michael Garron)
University Health Network

**CENTRAL LHIN**
Humber River Regional Hospital
Markham Stouffville Hospital
North York General Hospital
Southlake Regional Health Centre
York Central Hospital (Mackenzie Health)

**CENTRAL EAST LHIN**
Peterborough Regional Health Centre
Ross Memorial Hospital
Rouge Valley Health System
The Scarborough Hospital

**SOUTH EAST LHIN**
Brockville General Hospital

**CHAMPLAIN LHIN**
Cornwall Community Hospital
Montfort Hospital
Queensway Carleton

**NORTH SIMCOE MUSKOKA LHIN**
Orillia Soldiers Memorial Hospital
Royal Victoria Hospital
Waypoint Centre for Mental Health

**NORTH EAST LHIN**
Health Sciences North
North Bay Regional Health Centre
Sault Area Hospital

**NORTH WEST LHIN**
Lake of the Woods District Hospital
Thunder Bay Regional Health Sciences

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