Association of General Hospital Psychiatric Services

The AGHPS Environmental Scan 2018

ENVIRONMENTAL SCAN PROJECT REPORT

THE AGHPS IS PLEASED TO DISTRIBUTE THIS REPORT TO STRATEGIC STAKEHOLDERS.

IT REPRESENTS A SIGNIFICANT OPPORTUNITY FOR ONTARIO LEADERS TO PARTNER ON A NEW LANDSCAPE FOR THE CARE OF THOSE WITH SERIOUS MENTAL ILLNESS.

BACKGROUND

Environmental Scan for Schedule I Hospitals

Purpose:

- **To develop a complete snapshot and detailed spreadsheet of structures, systems, and practices on significant issues in Schedule I hospitals**

- **To utilize the resulting data to provide insight and strategic direction for the AGHPS and Schedule I hospital members.**

Project Description and Outcome

Interview leaders from **all** Schedule I hospitals

A comprehensive summary of a collective conversation

Increase our understanding of the current situation and inform a deep awareness of how to collectively move forward

Provide a foundation for Schedule I leaders and the AGHPS in guiding priorities and strategic direction

Determined Topics

- ✓ Board and stakeholder consultation to determine 2-4 topics for investigation
- ✓ Designed questions to reflect the information required
- ✓ Tested the interview instrument
- ✓ Finalized content and process for interviews

Interview Design

40 minute telephone interview

Goal to interview 60 Schedule I hospitals (excluded CHEO)

We completed 38 interviews 63%

Included large academic and community

All LHINs represented

Topics

The report draws conclusions on 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 injectables (LAI)
- Practices and Protocols for patients admitted with Dementia (without delirium)
- Discharge strategies for decreasing repeat 30 day presentations
- Protocols for “admit no bed” or code gridlock in MH
- Protocols for medical clearance (stability)
- Protocols for patients with acute intoxication
- Protocols for psychiatry coverage 24/7
- Assisted Dying from Perspective of Psychiatry

I. Section on HQO Standards

Follow up within 1 week of discharge (Quality standards for Schizophrenia and Major Depression)

Individual Cognitive Behaviour Therapy for those with a primary dx of Schizophrenia

The option of a long-acting injectable antipsychotic medication for adults admitted to an inpatient setting with a primary diagnosis of Schizophrenia

Follow up within 1 week of discharge

36 aware of benchmark: 95%

2 not aware: 5%

Currently, does every patient with a primary dx of Schizophrenia or Major Depression have a f/u appointment within 7 days?

Yes: 11 (28.9%)

No: 22 (57.9%)

Not sure: 5 (13.2%)

What We Heard

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

What constitutes follow up?

Is follow up one appointment? 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

CBT for those with a primary dx of Schizophrenia

37 hospitals responded to the questions on CBT

Aware of benchmark

35 (94.6%) said yes **2 (5.4%) said no**

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**

Relative Importance

Most important	Very important	Important	Not very important	Not at all important
3 (8.11%)	8 (21.62%)	17 (45.95%)	9 (24.32%)	0 (0%)

What We Heard

- Despite the range of level of importance this was given, there is a real effort to work towards complying with a mandate.
- There is no consensus that it should include inpatients
- What is sufficient training and oversight? How will we fund that level of education?
  - 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

Long Acting Injectables (LAIs)

Long acting injectable antipsychotic medications (LAIs) are offered in all 38 hospitals surveyed.

The capacity to administer LAI's is 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 LAI's if prescribed although there were several comments on barriers to administration.

What We Heard

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, 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 LOS
- Patient willingness and accessibility to funding (benefits)
- “Cultural” approaches within groups of psychiatrists – comfort, prior experience, champions

II. Emergency Dept. volumes and practices

Emergency Department volumes and practices for patients presenting with mental health issues are significant drivers of system access and care for Schedule I hospitals.

We asked about

Discharge strategies for decreasing repeat 30 day presentations

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

Protocols for medical clearance

Protocols for patients with acute intoxication

Assuming psychiatrists do not stay in house 24/7, protocols after hours

Discharge strategies for Decreasing repeat 30 day presentation

Yes: 33 (94.29%) No: 2 (5.71%)

N/A: 3 – no ER

Of the 33 hospitals that indicated they had strategies in place to address this:

- ✓ Strategies at the hospital level: 16 (48.48%)
- ✓ Strategies at the LHIN or regional level: 7 (21.21%)
- ✓ Strategies at both levels: 10 (30.30%)

Measuring 30 day Strategies

23 hospitals indicate measuring or evaluating 30 day strategies but there is no apparent consistent metrics or methodologies.

3 hospitals referred to a “scorecard”.

A Final Thought

One survey participant – a caution

Presenting to the hospital again means that they know there is a place to go where they can get the needed support right away. 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)

Capacity and Surge

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

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

What We Heard

Surge. There are some surge beds. The numbers in each hospital vary but are typically small (1-3) and often are not associated with any additional staffing.

LHIN level strategies such as bed registries / Criticall

Negotiation and prioritizing is central to managing

There appears to be fairly formal or structured approaches to address volumes and capacity and more consistencies in the language describing the norms and protocols.

Capacity and SURGE

The centrepiece 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

A Final Thought

While we 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.

Medical Clearance

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

What We Heard

- Medical Clearance vs. Medical Stability. Is this a position we can adopt provincially?
- Varying degree of concern and contention. However, it is clearly an issue for many and was described by one hospital as a hot topic
- In almost all cases the decision rests with the ER physician
- Examples of attempts to develop standards and best practices. However there is no evidence of acceptance of these standards.

Acute Intoxication

We note a trend utilizing the Clinical Institute Withdrawal Assessment Score (CIWA). This was mentioned specifically by 12 hospitals

What We Heard

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.

Protocols for 24/7 coverage

Extensive use of clinical expertise such as crisis teams

While we did hear some cases of delayed decision making we did not hear of any significant negative outcomes.

Is there an opportunity to acknowledge, support and augment the role of the current system? By shining a lens on what is currently the professional practice we might find creative solutions

III. Dementia without Delirium

Collegial relationships, while likely to have an impact on the satisfaction of the professionals, is not an apparent driver of decisions regarding admission and care

The driver is behaviour

IV. Assistance in Dying

34 have a formal process

3 Catholic hospitals that refer

1 N/A – CAMH out of scope

Psychiatrists are involved in varying degrees.

It is generally the practice to consult psychiatry on a referral basis as indicated.

Overall we found no concerns relating specifically to the role of psychiatry

Themes

For the most part the answers clustered into 3 major categories.

- Access, Capacity, Volumes, SURGE
- Violence and Security
- The Lack of a System for Mental Health

Where do we go from here?

We believe that there is real opportunity to “connect the dots” into a coordinated system of care for those with serious mental illness. The purpose of conducting this Environmental Scan was to determine what challenges and strategies leaders in Schedule I hospitals face. We will devote our efforts to collaborating with stakeholders to find a path to a system we can all be proud of.

Acknowledgements

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Participating Hospitals

- Baycrest Hospital
- Brantford General Hospital
- Brockville General Hospital
- CAMH
- Cornwall Community Hospital
- Grand River Hospital
- Grey Bruce Health Services
- Halton Healthcare Services
- Health Sciences North
- Hotel Dieu Grace Hospital
- Humber River Regional Hospital
- Huron Perth Healthcare Alliance
- Joseph Brant Memorial Hospital
- Lake of the Woods District Hospital
- London Health Sciences Centre
- Mackenzie Health
- Markham Stouffville Hospital
- Michael Garron Hospital
- Montfort Hospital
- Montfort Hospital
- Niagara Health System
- North Bay Regional Health Centre
- North York General Hospital
- Peterborough Regional Health Centre
- Queensway Carleton
- Ross Memorial Hospital
- Rouge Valley Health System
- Royal Victoria Hospital
- Sault Area Hospital
- Southlake Regional Health Centre
- St Michael's Hospital
- Sunnybrook Health Sciences Centre
- The Scarborough Hospital
- Thunder Bay Regional Health Sciences
- University Health Network
- Waypoint Centre for Mental Health
- William Osler Health Centre
- Woodstock General Hospital