Specialized Inpatient Mental Health Units in Ontario: Their History and Program Characteristics

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In Ontario, the psychiatric hospitals currently provide the only available specialized inpatient treatment settings for individuals with developmental disabilities and mental health needs. The policy context for service provided by five specialized inpatient units is reviewed, with the results of a survey regarding the number of beds, team composition, staffing ratio and environmental adaptations. Since 1990, there has been an overall expansion of the specialized services offered by the psychiatric hospitals. Additionally, all programs have adopted a multidisciplinary biopsychosocial approach and have undertaken environmental adaptations to address the specific needs of individuals with developmental disabilities and mental health needs living in a hospital environment. The role of these units within the developing continuum of specialized services in Ontario requires further consideration by policy makers and service providers.

Keywords: aggression, bipolar, developmental disability, inpatient, intellectual disability, mental retardation, multidisciplinary, policy, psychiatric, psychiatric disorder, restraint, schizophrenia, seclusion

Dual diagnosis in Ontario is defined as developmental disability with mental health need. (DD-MH) Psychiatric hospitals operated by the provincial Ministry of Health and Long Term Care have a long history of providing specialized DD-MH inpatient services. Lunsky and her colleagues found that one in five inpatients served by the nine psychiatric hospitals have patients with DD-MH. Seven of the nine psychiatric hospitals offer specialized inpatient and/or outpatient programs for the patients with DD-MH. (Ibid)

Much research has been published regarding the epidemiology of individuals with a DD-MH in institutions and community settings. A smaller number of articles specifically address the demographic characteristics of inpatients and service outcomes provided by specialized DD-MH units. Few studies actually consider the program characteristics of specialized inpatient units for individuals with DD-MH.

A survey of the five specialized inpatient units currently operating in Ontario’s psychiatric hospitals was undertaken in 2003. Questions included the number of beds, team composition, staffing ratio and environmental adaptations. The survey was originally undertaken as a means to inform decision making regarding staffing and structural changes at the Dual Diagnosis Program, Centre for Addiction and Mental Health, one of the newer programs in the province. The results are of interest given the current period of hospital restructuring and realignment, shrinking resources, the continuing demands for specialized DD-MH services and the expansion opportunities that have arisen during this period of system change.

Ontario has the largest population of the ten provinces in Canada at approximately eleven million. The true prevalence (people who might be expected statistically to have a developmental disability) is between 2-3% of the general population, 220,000-330,000 individuals in Ontario. The literature on prevalence of DD-MH ranges from 14% to 70%, varying due to the diagnostic criteria used, the nature of the study, and whether autism is included. A conservative estimate of 38% has been used in Ontario as the prevalence rate for DD-MH. Based on these figures it is estimated that there are 104,500 individuals with a DD-MH.

History of Ontario Institutions in the Developmental and Mental Health Sectors

Specialized services for individuals with DD-MH in Ontario have their historical base in institutions located within the mental health and developmental service sectors. Until 1974, the institutions for people with mental illness or developmental disability fell under the auspices of the Ministry of Health and Long Term Care. In 1974 the Developmental Services Act consolidated community-based and institutional services for those with developmental disability under the Ministry of Community and Social Services to emphasize the shift in policy direction toward normalization and community care.
At the time of the Developmental Services Act there were 20 institutions for adults with developmental disabilities that moved over to the Ministry of Community and Social Services. The total population of these institutions was as high as 12,000. In addition to their long term care role, over time, many of these institutions developed specialized multidisciplinary inpatient or community services focused on assessment, behavior management, sex offender, secure care and treatment for children or adults with mental health needs. (Ibid) From the time of this shift, the government policy direction has been to close these institutions and expand community-based services for individuals with developmental disabilities. Between 1970 and 2002, 17 institutions were closed, and currently approximately 1,050 residents remain in three institutions. (Personal Communication; Ministry of Community and Social Services, Feb 23, 2004). These are scheduled for closure by 2009.

In the mental health sector the psychiatric hospitals originally opened as asylums, dating back to the mid-1800’s and provided a catchall for housing those with mental illness, including non-organic as well as organic diseases such as epilepsy, arteriosclerosis, alcoholism and mental retardation. In 1959, the population of the psychiatric hospitals was approximately 15,739. (Ibid) Deinstitutionalization within this sector was also initiated in the 1970’s with the closure of three psychiatric hospitals. (Ibid) Through the 1980’s and early 1990’s there remained ten psychiatric hospitals directly operated by the Ontario government, Ministry of Health and Long Term Care. These hospitals operate under the Mental Health Act (revised in 2003) with the capacity to detain, restrain, or seclude individuals if they are a danger to themselves or others.

Three specialized units for patients with DD-MH within the psychiatric hospitals were initiated in the 1970’s. By 1990, five of the ten facilities were operating specialized inpatient programs (Brockville, Hamilton, Penetanguishene, St. Thomas and Whitby) with some also offering outpatient services. There were a total of 118 beds for patients with DD-MH. The criteria for admission to these units varied including severe behavior dysfunction, psychiatric disorder, severe aggression or self-abuse, mental retardation as defined in the Diagnostic Statistical Manual or functional retardation.

Restructuring of the health system was initiated by the Health Services Restructuring Commission in 1996. The Commission provided advice to the Ontario Minister of Health and Long Term Care regarding the funding required to restructure hospitals and to enhance other health care services to meet the goal of developing an integrated health services system. Within this context, the Commission recommended either divestment (from direct government administration) or closure of psychiatric hospitals and shifting of programs to the public hospital sector. Community mental health reinvestments were tied to the closure and bed reductions that were to result from the restructured psychiatric hospitals. However, there was little or no specific reference to how the specialized DD-MH programs would be addressed within the Commission recommendations. By 2004, there remain nine psychiatric hospital facilities, some of which were or continue to be in the process of divestment or amalgamation with other hospitals, operating under the Public Hospitals Act (e.g., private Boards of Directors).

**Current Status of Specialized DD-MH Units in Psychiatric Hospitals**

During this period of change in the 1990’s the Ministry of Health and Long Term Care and the Ministry of Community and Social Services collaborated to establish “Policy Guideline for the Provision of Services to Persons with Dual Diagnosis.” This document provided a much needed provincial framework to support the development of a continuum of community-based as well as specialized supports and services within and across the mental health and developmental sectors. The Guideline identified the roles and functions of various components within each sector. Table 1 summarizes the roles established for the psychiatric hospitals and remaining Ministry of Community and Social Service facilities.

The policy guideline also identified that general hospitals were to provide emergency and short term stabilization and treatment, while both the community-based developmental and mental health sectors were to provide residential, day and case management services. The guideline reflects the policy priorities of the time within each ministry with regard to the role of institutions, e.g., the tertiary role of psychiatric hospitals and the closure of Ministry of Community and Social Services facilities. Along with the closure policy of the Ministry of Community and Social Services institutions, a “no admission” policy to those
remaining institutions was in effect. The responsibility for specialized services was, therefore, to be located primarily in the psychiatric hospitals, with community mental health programs having the role of “participating in...development of specialized services...with other sectors.” (p.11,1997) The developmental sector role was more focused on long term community-based care, and there was no specific mention in the guideline of their role in providing specialized services.

Within this environment of financial pressures during the 1990's, hospital restructuring and taking into account the various changes across all psychiatric hospitals, there in fact appears to have been a net gain in the specialized DD-MH services offered by the psychiatric hospitals. When compared to 1990, seven of nine Psychiatric Hospitals provide DD-MH inpatient and/or outpatient services. The current status of the dual diagnosis services in the psychiatric hospitals is summarized as follows. Since 1990:

- One new specialized inpatient unit opened, one specialized inpatient unit closed and one specialized inpatient unit transferred to another psychiatric hospital. Closure of another existing specialized inpatient unit as a result of divestment and amalgamation has been planned, but has been delayed in part due to challenges related to planning the discharge of current inpatients. In summary by 2003 there remain a total of five specialized inpatient units.

- Addition of specialized multidisciplinary team outpatient services in four of the five psychiatric hospitals that have inpatient units.

- Addition of specialized outpatient services only, at another psychiatric hospital and continuation of outpatient services where one inpatient unit was closed.

- Addition of a specialized day treatment service for outpatients offered by one of the five programs.

- Development of additional inpatient services in two other psychiatric hospitals is being considered, possibly to be located within existing psychiatric units (as opposed to stand alone units).

**The Patient Population in Psychiatric Hospitals**

Lunsky et al.\textsuperscript{13} completed a study of the demographic and diagnostic characteristics and clinical support needs of individuals with DD-MH in all nine psychiatric hospitals. DD-MH was defined as individuals with either a diagnosis of mental retardation/developmental handicap or developmental disability, based on the Colorado
Client Assessment Record. Out of a total of 12,960 inpatients and outpatients in the nine psychiatric hospitals, 1,714 (13%) were determined to have DD-MH. Additionally, of all inpatients served by the psychiatric hospitals, close to 20% have DD-MH. The specialized DD-MH inpatient and outpatient programs within the psychiatric hospitals were found to serve 19% of all patients with DD-MH in those hospitals. (Ibid) Patients in these specialized programs were younger (average age of 39), more likely to be male (70%) and more likely to be violent or aggressive in comparison to those patients with DD-MH found in other programs within the psychiatric hospitals.

**Program Characteristics of DD-MH Inpatient Units**

A survey was sent in May 2003 to the five psychiatric hospital facilities that were known to have established inpatient DD-MH Programs. Programs were asked to report on catchment area population, bed numbers, admission criteria, staffing complement, length of stay, environmental adaptations and the range of services offered.

Two of the five programs are located within Academic Health Science Centres. The population size of the catchment areas for each of the programs ranges from approximately 530,000 (Penetang) to approximately 3.6 million (Toronto). They also serve a range of urban and rural regions. Table 2 provides a summary of the basic demographic aspects of each program.

**Admission Criteria**

The criteria for admission is relatively consistent across all five programs: medical stability, diagnosis of mental retardation consistent with DSM-IV-TR, and residence within the catchment area. Each of the programs, however, referred to the psychiatric aspect of the developmental disability using somewhat different language, e.g., indication of mental health problem or psychiatric illness or emotional/behavioral difficulties or history of indicators of mental illness.

**Staffing Complement**

Three out five units based staffing on eight-hour shifts (rather than 12-hour shifts). The primary professional background of staff on shifts were Registered Nurses and Registered Practical Nurses. However, three out of five programs included one non-nursing staff within the shifts, e.g., college level prepared staff with Developmental Service or Child and Youth Worker diplomas. All programs had additional day staff including at least a social worker and a recreation therapist. Four of five programs had an Occupational Therapist and at least a part-time Psychologist. Programs reported having a variety of other staff including behavior therapist, nurse practitioner, psychometrist, vocational counselor, and advanced practice nurse. Psychiatric care was provided through a range of part-time (often half-time) and full-time arrangements. Two programs noted having a part-time general practitioner.

**Environmental Adaptations**

Programs were specifically asked if there were special adaptations within their units to address the issue of challenging behavior. Two of the programs reported that the unit was rebuilt to their specifications in recent years. All five programs had undertaken at least two of the following adaptations:

- Two programs noted that they had a “Quiet Room” that incorporated special touches such as piped in music, bean bag chair, pine wainscoting, and a wall mural.
- Padded seclusion rooms were available in two programs; a third program was planning for this addition.
- Two programs also had built Snoezelen rooms, one program of which has been involved in research projects related to the impact of Snoezelen on aggressive behaviors. One program had access to a Snoezelen cart and a second program is planning to build a room. Snoezelen is a commercially registered trade name for a multisensory intervention designed to provide stimulation and relaxation. The senses of touch, hearing, sight, smell and taste are triggered through the use of soft music, aromatherapy, textured objects, colored lights and/or favorite foods. It has been used for both individuals with developmental disabilities and the elderly with dementia in the context of leisure, education and/or therapy.
- One program reported the inclusion of a four bed Intensive Observation Unit within the structure of the inpatient unit, and another program was planning for this.
TABLE 2. DEMOGRAPHIC ASPECTS OF DD-MH UNITS

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>START DATE</th>
<th>BED NUMBERS (1990 Bed numbers)</th>
<th>AGE RANGE</th>
<th>STAFF TO CLIENT RATIO - BASED ON DAY SHIFT</th>
<th>LENGTH OF STAY **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brockville</td>
<td>1978</td>
<td>29 (29)</td>
<td>16 years +</td>
<td>1 : 4.8</td>
<td>730 days</td>
</tr>
<tr>
<td>Penetang</td>
<td>1979</td>
<td>25 (25)</td>
<td>16 years +</td>
<td>1 : 2.7</td>
<td>145 days</td>
</tr>
<tr>
<td>Whitby</td>
<td>1990</td>
<td>20 (20)</td>
<td>18 – 65</td>
<td>1 : 2.8</td>
<td>129 days</td>
</tr>
<tr>
<td>CAMH</td>
<td>1997</td>
<td>15 (0)</td>
<td>16 years +</td>
<td>1 : 2.14</td>
<td>735 days</td>
</tr>
<tr>
<td>Regional Mental Health Care-London</td>
<td>(1974 original unit opened at St. Thomas) 2003 relocation as a result of amalgamation of two psychiatric hospitals</td>
<td>18 (24)</td>
<td>18 – 64</td>
<td>1 : 3.6</td>
<td>April 2003-Jan. 2004 24-114 days</td>
</tr>
</tbody>
</table>

**Length of Stay is based on 2002-2003 figures. Calculations across each of the programs are different and not comparable.

The total number of beds currently stands at 107. The decrease from 118 in 1990 is primarily due to the closure of a 20 bed unit in Hamilton.

- One program, located on the ground floor, added to their limited living space by creating a private fenced courtyard with gardens, a waterfall, fish pond, bird bath and feeders that is cared for by patients and staff.
- Two programs reported gender separation within the units.

CONTINUUM OF SERVICES

All programs offered day programming for inpatients as part of the program and/or through hospital wide services. One program offered a specialized Day Treatment Program for both inpatients and outpatients (as an alternative to inpatient admission and step down at discharge from inpatient). All five programs reported offering a range of outpatient multidisciplinary services such as time limited consultation, assessment and treatment provided by different complements of staff: two nurses in one case, a social worker and psychiatrist in another, two multidisciplinary community teams and one Specialized DD-MH Assertive Community Treatment team.

DISCUSSION

The number of beds in each of the Ontario programs appears to bear no relation to the size of the population within each catchment area. Admission criteria regarding the definition of developmental disability is more consistent across the five programs than was reported over a decade ago. The different language used by the programs to define the mental health aspect of developmental disability may reflect the struggle that has existed to define this term, particularly in relation to the “fit” within mental health policy in Ontario. The definition of “dual diagnosis” that was adopted by the province in 1997 in the Interministerial Dual Diagnosis Guideline was “individuals with a developmental disability and mental health needs.” The term “mental health needs” was deliberately broad in order to address the experience by consumers and families of exclusion from the mental health system due to a lack of a “diagnosed” Axis 1 mental illness. In 1998 the Ministry of Health and Long Term Care also included “dual diagnosis” in their definition of “serious mental illness” with the intent that these individuals would have priority access to mental health services similar to individuals with schizophrenia or bipolar disorder. Unfortunately, some community and institutional mental health services continue to require a diagnosed psychiatric illness (assumed to be an Axis 1 diagnosis) before an individual with a developmental disability can receive services. The language chosen by the specialized inpatient programs to describe the target population (e.g., indication or history of indicators of mental illness) may be an attempt to bridge between what has become day to day practice within the mental
With regard to age criteria the general mandate of psychiatric hospitals is to serve individuals age 18 and older. The fact that three out of five programs offer services beginning at age 16 may be related to service gaps and/or adaptations within a particular region. For example, if a psychiatric hospital has an existing adolescent program that will admit individuals with DD-MH, then the specialized program may not accept individuals below age 18. This could also apply to the upper age range of 65 in relation to geriatric services (two of the five programs have established this limit). The provision of services beginning at age 16 by a specialized DD-MH program may provide a means to support bridging between the child and adult service systems for those with more severe difficulties, as this can often be a challenging transitional period.

Historically, the psychiatric hospitals were established to provide chronic care. Therefore, it is not surprising that the length of stay in the DD-MH Inpatient Units tends to be in months or years. Lunskey et al.\textsuperscript{14} reported that 37\% of inpatients with DD-MH have been in the psychiatric hospitals for longer than five years. They also tend to remain inpatients not because of severity of their difficulties, but because there are no appropriate places for discharge. (Ibid) This finding is consistent with other studies of specialized units.\textsuperscript{23} However, the Ontario policy guideline and the overall direction of mental health reform has been to shift the role of psychiatric hospitals to offer more specialized inpatient and time limited services. The impact of the current policy direction has yet to be realized.

The multidisciplinary staffing found in the five specialized inpatient units clearly demonstrates a commitment to provide services based on a biopsychosocial approach. Additionally, three out of the five programs reported hiring of “non-traditional” health care practitioners that are more often found in the community and developmental service sectors, e.g., developmental service workers, child and youth workers or behavior therapists. This suggests efforts to further enhance the treatment approaches through the integration of developmental and mental health perspectives. The experience of these programs is that hiring and staff retention can be challenging as few of those who apply for positions to the specialized units have received training in the field of developmental disabilities or DD-MH. For those non-traditional practitioners, few have experience working in hospital settings and/or with the seriously mentally ill.

The hiring and retention issues are particularly true of psychiatry, where only a handful of physicians throughout Ontario can be counted as working full-time in the field. This reflects a general decrease in psychiatric and medical services working in the field of developmental disabilities through this period of deinstitutionalization. McCreary,\textsuperscript{16} in a 1974 cross Canada survey, found 74 physicians working full-time in institutions for persons with intellectual disabilities. In a similar survey in 2001, it was difficult to find physicians to complete the questionnaire.\textsuperscript{15}

Other staffing issues that can effect hiring and retention for the psychiatric hospitals include changes in practice. For example, increasingly nurses working in psychiatry prefer to adapt the practice of 12 hour shifts similar to that of their colleagues in general medicine. This facilitates a greater balance in personal life and supports engagement in other part-time pursuits. Two out of the five DD-MH programs have adopted 12 hour shifts. Further study of this model would be helpful to understand the impact on staff stress and the work environment in relation to working with a very high need population for 12 hours at a time as well as the impact on continuity of care within the intensive multidisciplinary team approach found in DD-MH inpatient units.

While there has been an overall decrease in the number of specialized beds available in the psychiatric hospitals for individuals with DD-MH since 1990, (from 118 to 107) this must be considered within the context of the general shift from institutional to community care in both the developmental and mental health sectors. During this same period the psychiatric hospital specialized DD-MH programs have also incorporated less intrusive community-based services that are also consistent with what is now understood to be more appropriate care and treatment in the field.

In summary, the experience in Ontario has been that specialized inpatient treatment for individuals with DD-MH has, over time, become the domain of the mental health sector. Despite the last 15 years of shifting ground for the psychiatric hospitals, five inpatient units remain in the province, providing specialized
multidisciplinary treatment, and their services have expanded to incorporate community-based and less intrusive alternatives to hospitalization. Each program has also made many similar environmental adaptations to address the special needs of this population.

Currently the psychiatric hospitals provide the only available secure settings in Ontario that operate within a legal context that permits the containment of individuals who present with the most challenging of difficulties and who are unable to live in existing community resources. Further study comparing those individuals with DD-MH found within the Forensic Units of the psychiatric hospitals to those in the DD-MH Units would enhance the understanding of the specialized role of the psychiatric hospitals within the continuum of services in Ontario.

Watts et al 23 completed a study identifying the factors delaying discharge of psychiatric inpatients from a specialized unit in the UK. That study noted that while deinstitutionalization has led to the expectation that individuals with more complex and challenging needs be cared for in the community, the community is not yet ready to cope with these needs. Further consideration is required of whether the inpatient units of the psychiatric hospitals (DD-MH or Forensic) are the most effective and best means of providing specialized care to those with more complex needs.

In 2004, the Ministry of Community and Social Services announced their intent to update current policies regarding developmental disabilities. The announcement includes a plan to close the remaining institutions by 2009, as well as enhancement of specialized resources for the population of individuals with a developmental disability and co-existing mental health and/or behavioral challenges. 18 This latter emphasis by the developmental service sector to undertake a more formal role related to specialized services is a welcome direction. Hopefully this will lead to opportunities for increased collaboration and clarification of roles with the mental health sector regarding how the specialized service needs of those individuals who present with more challenging difficulties are to be met.

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