A Review of the Plan to Close More than Half of the Existing Residential Addiction Treatment Beds and Hospital Crisis/Safe Beds from North Bay Regional Health Centre

Ontario Health Coalition

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Introduction & Summary

In September, North Bay mayor Al McDonald Mayor convened a meeting of organizations to discuss addictions, homelessness, mental health and poverty issues in North Bay. Out of that round table meeting and under the authorization of the North East Local Health Integration Network (NE LHIN), the government-appointed body responsible for regional health planning, a proposal is being implemented to close 2 safe/crisis beds at North Bay Regional Health Centre and 29 residential addictions treatment beds at the King Street location administered by the hospital. The co chair of the Mayor's Round Table meeting, Mary Davis is also the executive director of Nipissing Mental Health Housing and Support Services, which is merging with the North Bay Recovery Home (whose executive director Wendy Prieur also sits on the roundtable) and a peer support network.[1] The amalgamated organization will be the prime beneficiary of the recommendations coming out of the roundtable from the $1,115,000 being cut from the hospital ($700,000 cut to close the 29 residential addictions beds program and $415,000 cut to close the 2 crisis/safe beds[2]). They are also slated to get $185,000 in new funding for crisis/safe beds out of this process.[3] According to the current plan, the hospital will continue to administer a day program.[4] The hospital's Withdrawal Management Services (detox) beds are also under review.[5]

There has been a lot of misinformation and misunderstanding about this plan. Upon hearing about the significant cuts to the hospital's services, the Ontario Health Coalition undertook to investigate. We met with the leadership of the NE LHIN, with front-line staff who provide care on the residential treatment unit under threat, we reviewed the two reports by Dr. Rush et al. and read all the documents available from the NE LHIN. We confirmed that the plan is indeed to close 29 residential treatment beds without replacement, despite the fact that there are wait lists both for the so-called community residential treatment beds and for the residential treatment beds administered by the hospital. To be clear, the plan is to eliminate more than half of the existing residential treatment beds in North Bay and the NE region, despite wait lists for residential treatment. We also found that the plan is to close hospital crisis/safe beds despite the fact that these beds are reported to be less than what is needed already in the hospital. Despite repeated claims that the plans have been generated by Dr. Rush's reports, we could not find any recommendation in either the 2016 or the

[1] Information about the amalgamation provided in conversation with the NE LHIN on January 17, 2020.

[2] Financial information from conversations with NE LHIN on January 17, 2020 and January 31, 2020.

[3] From conversation with NE LHIN on January 31, 2020.

[4] In conversations with the NE LHIN this was referred to as a day/evening program but in conversations with front-line staff it is currently a day program that closes in the evening. The hospital is losing funding as a result of the plans and there is no new funding in the current plan to extend its hours.

[5] From conversation with NE LHIN on January 31, 2020.

2018 Rush reports recommending the closure of the 29 residential treatment beds and the 2 crisis/safe beds at the King St. site (administered by the hospital).

What we did find, was an assessment, based on Canada-wide statistics of projected need, of all addiction services (hospital and "community") in North Bay and the NE region. We found recommendations for a deeper review of the residential programs that does not appear to have been done. We also found a listing of possible service gaps that include significant gaps in both hospital and community services that require funding and planning support. We discovered that there has been no assessment of the impact on patients on the wait list of the proposed changes and that inferences about the interchangeability of different types of programs were unsupported by any evidence. We found no plan to assess or mitigate impact on people already waiting for residential treatment beds. We found that a rather arbitrary distinction has been made between the hospital-administered services and the so-called "community" services in North Bay, as if the hospital services are somehow not in the community and not a vital component in the continuum of care for patients and residents. We were left with deep concerns about what will happen to people waiting for residential treatment and what will happen to the wait lists when the number of available beds is cut in more than half and we have significant questions about the process used to make the plan.

Ontario has cut our hospitals more mercilessly than virtually anywhere else cutting far more deeply than any national or international benchmarking can support, and this includes North Bay that has seen relentless hospital cuts. As such, the onus should be on those advocating for more hospital cuts to provide evidence to support their proposals. In assessing these plans, the Ontario Health Coalition adopts a public interest point of view. Is planning based on evidence and sound planning to meet community need or is it simply part of a policy to cut costs through endless hospital downsizing or an ideology of dehospitalization? Does the plan result in offloading of patients to lesser levels of care that are inadequate to meet the complexity of their care needs? Does the plan result in the privatization of health care – in terms of out-of-pocket and private costs for patients or for-profit takeover of ownership of health care services? Does the plan undermine decent wages and working conditions for care workers? Does the plan improve access to and quality of care or does it make them worse? We were not reassured by the results of our investigation. Much of the information we were given does not match the reports of frontline staff and/or vital information needed to make such a decision is missing. There are existing wait lists for residential treatment beds at both sites and the fact is that withdrawal management is not the same as residential treatment. There are significant differences between the "community" residential treatment program and the hospital-administered residential treatment program in everything from admission criteria and accessibility to complexity of care provided. There is no evaluation of outcomes. There is reported undercapacity in the hospital for crisis/safe beds already and a lack of any clear assessment of the different criteria and level of care in the proposed crisis/safe beds in the "community. There is no analysis of the impact on care workers.

Failure to Recognize and Respect the Continuum of Care Needed by Patients and Residents

For most Ontarians, our hospitals are a vital part of our communities. Ontarians understand that we need a continuum of care – from our family doctor or nurse practitioner to hospital, to long-term and home care, to health care agencies and support services. Community care programs are vital as are hospital programs for a person who is in need. Fostering competitiveness among provider organizations can be dangerous as it can jeopardize needed care. However, for decades, Ministers of

Health of various stripes have closed down capacity in local public hospitals stating that they were "moving care out to the community". In the early years the push was to enable the elderly to choose to age at home, but in the last two decades or more, the push has been to cut costs for public hospitals by downsizing them endlessly, often with little or no regard for the consequence for patients. In fact, in most cases today, the mantra of "moving care out" has simply become a cover for cuts to needed services. The data is very clear: Ontario has already closed more hospital beds than any province in Canada and more than any developed nation. Our governments' policies of endless hospital downsizing are the most radical of any peer jurisdiction. In our 35 years of work on these issues we have found that hospital programs are often not comparable to community programs. Thousands of Ontarians are suffering from poor access to hospital care as a result of cuts that, by any measure, are too deep. There is also urgent need for more "community" health care and social services and residents are suffering from inability to access those programs and supports. But in the world of Ontario's health care today, having been given tacit permission by political leaders anxious to cover for hospital downsizing, many administrators foster an arbitrary distinction between the hospital and "the community" and support cuts to hospital programs in order to take more funding for their own programs. The reality is that Ontario funds health care services at the second lowest rate in Canada and hospital services at the lowest.[6] There is plenty of room to improve funding across the continuum even just to reach the average of the rest of the country.

A further reality is that every program run by a different governing body, whether it is considered to be "hospital" or "community", has its own admission criteria, culture and level of service, among other differences, set by the provider organization. These differences matter because they have a significant impact on access for patients, on the experience of treatments and supports, and on outcomes. But in the documents reviewing addictions services in North Bay and the NE region, including the two Rush reports and the documents provided to us by the NE LHIN, there is no evaluation of the different admission criteria, accessibility for patients, wait lists, outcomes and quality measures between the hospital-administered programs and those that exist currently "in the community" or that are proposed to be "in the community". There is also no documentation of any review of the complexity or intensiveness of the two different residential programs nor of the current crisis/safe beds and the proposed crisis/safe beds. Both hospital-administered residential beds (located in the community at the King Street site) and the "community" residential beds are listed in the same category in the 2018 Rush report as "Community Intensive Residential Treatment" although there are significant differences between the two programs. It is not clear what methodology was used to assign both programs to this category and we cannot assess whether this is supported by the evidence.

A Review of the Facts: Results of Our Investigation

In North Bay, the decision has been made to close down the existing 29-bed hospital administered addictions and the hospital crisis (safe) beds. The rationale for this scheme is laid out in a January 7, 2020 press release by the NE LHIN. It is further claimed that the plan is based on recommendations by Dr. Rush in his 2018 report. We reviewed all the available documents and found that a number of the claims made to support the service closures are misleading and vital information has been omitted. Here are the facts:

1. There are currently wait lists for both the hospital administered addictions residential treatment beds on King St. and the North Bay Recovery Home's residential beds. There has

[6] https://www.ontariohealthcoalition.ca/wp-content/uploads/ohc-final-submission-1.pdf

been no actual assessment done of the impact of closing more than ½ of the existing residential treatment beds on the people waiting for services.

2. The residential treatment programs are different programs than withdrawal management programs. They are both part of a needed continuum of care. There is no evidence that the people waiting for the residential treatment programs are waiting for withdrawal management services (WMS) or could be appropriately or effectively served by those programs. Yet the plan is to close residential treatment beds and move funding to WMS.
3. There is an arbitrary distinction that has been fostered between so-called “community” health services. The reality is that the “hospital” addictions beds are located on King St. downtown in a building separate from the hospital. Further the reality is that both hospital and non-hospital services are needed by patients and residents and that sound practices would form a continuum of care for residents and patients in need.
4. There is a claim in the January 7 NE LHIN news release stating that residential treatment requires “at minimum” individuals to plan up to six months for their child care, mortgage, leave of absence from work. However, the residential addictions program administered by the hospital is a 21-day program (< 1 month). There is no requirement for six months’ leaves etc. Yet this is the first rationale given in the press release for the hospital cuts and changes in North Bay. On the other hand, the North Bay Recovery Home “community” residential program is a 3-month program, thus longer than the hospital-administered program and presumably more difficult for people to afford under the terms described in the press release. There was no proposal to cut it. (Note: we are not advocating for the latter service to be cut, we are just noting that the rationale given does not make any sense and that the two programs appear to have been treated very differently without any sound evidence to do so.)
5. We could find no assessment of the actual patients on the wait list for the residential treatment program that is going to be eliminated that could justify the claim in the same press release that those patients could be “better treated through addictions day/evening programs”. We found that there was a survey reported to the Mayor’s roundtable but it surveyed only clients of a “community” program. There has been no evaluation of the people on the wait list for the residential treatment beds or the crisis beds that are under threat of closure.
6. Many have been led to believe that the planned service closure is based on Dr. Rush’s report. We read both his 2018 and his 2016 reports. In neither report is there any recommendation to close down the 29-bed residential addictions program and the 2 crisis/safe beds administered by the hospital. In fact, what that report says is:
    a. “The Regional Mental Health Program is of considerable importance in North Bay, the wider sub-region of Nipissing-Temiskaming, and of the NE LHIN as a whole. Their strong medical and psychiatric capacity and the mix of mental health and concurrent disorder services are of critical importance. The centre also administers the withdrawal management service and the 21-day residential treatment program, both critically important elements of the continuum of care.” Page 39, 2018 report.
    b. “There is significant strength in North Bay and the surrounding area with respect to addiction medicine and provision of ancillary support services, including counselling. This includes the methadone nurse at the WMS/residential treatment centre, an important and exemplary model for other WMS services regionally, if not provincially.” Page 41 -42, 2018 report.
7. The scheme that is moving forward appears to be based on a decision to cherry pick a few identified gaps from the Rush report while ignoring all gaps that would require enhanced hospital services, without regard for actual current wait lists for existing programs, ignoring

all references to the need for a more in-depth review of the facts and data regarding quality, access and occupancy; and that this is being used to justify closing down services that the report does not actually recommend be closed. Further, the actual recommendations that do exist in the Dr. Rush reports are not reflected in the plans that are being implemented. (See further notes on Dr. Rush's report and methodology below.)

In addition, we found the following:

1. There was no plan to cut and close the hospital residential addictions program and the crisis beds, nor to tie closing beds and services in North Bay to winning improved funding for enhanced withdrawal management services, without the process that has occurred in North Bay that has resulted in this scheme and the link between cutting one program to move money to a different program. In fact, many organizations, including the Ontario Health Coalition, have been advocating for improved mental health (and addictions) funding across the continuum and for improved hospital funding. This does not appear to have been considered as an option.
2. The claims of the NE LHIN executives to us regarding utilization of the hospital-administered residential addictions treatment program were completely at odds with the reports from front-line nurses who report that the program is well used and has a wait list.
3. Front-line staff at the hospital have never been consulted on the impact of these proposals.
4. There is no evidence on accessibility, quality or outcomes regarding the 29 NBRHC residential addictions treatment beds nor on the 22 North Bay Recovery Home beds. In our conversation on January 17, 2020, the LHIN did not know what the current wait lists are for each program, despite planning to close down more than half of the total beds available. The NE LHIN occupancy statistic that they gave us regarding the hospital-administered program is completely at odds with the reports from front-line nurses that provide the care in that program. As for quality, the LHIN informed us that quality data regarding both these programs was not available.
5. There are differing admissions criteria between the hospital administered program in the community and the so-called community program. There is no assessment or written information on the difference in the admission criteria, staffing levels and service levels between the different programs for both the residential treatment and the crisis/safe beds.
6. We are concerned about conflict of interest and the planning process in North Bay. Without in any way casting aspersions, it is in the public interest to ensure that anyone in a conflict of interest removed themselves from the discussions and vote when it came to transferring money from one program to another. There are clear conflict of interest requirements for both the City of North Bay and the NE Local Health Integration Network and we would expect that these extend to a roundtable process that involves allocations of funding. We could not find documentation available showing whether or how the roundtable discussions and decisions were made in a way that adheres to proper conflict of interest protections.

Notes on the Dr. Rush Reports (2018 and 2016)

The bottom line is that the Rush reports do not recommend the closure of the 31 hospital-administered beds. The reports treat addictions services as a continuum of care.

- The Rush report projections are based on a Canada-wide assessment of population need for certain types of care and Dr. Rush cautions that the exclusion of First Nations living in reserve communities from population health survey information and the needs of homeless people means that their substance use-related needs will be underestimated in the data presented (pp 3). This is significant as Indigenous Peoples comprise 13.4 per cent of the population of the region (pp 8).
- There are numerous parts of both the 2016 and 2018 Dr. Rush reports that treat the hospital and community services as a continuum of care, unlike the proposed cuts and restructuring in North Bay. In fact, in 2016, Dr. Rush observed that there were high tensions between so-called "community" organizations and the hospital and advised the LHIN to show leadership in bringing together the services collaboratively to serve people who require services from both (pp. 37). The reports show projects needs for a continuum of care including Withdrawal Management Services in the "community" and in the hospital, Residential and Non-Residential services in the "community" and in the hospital (pp. 12), projected unmet need for both "community" withdrawal management and services and supports, unmet need for more acute intoxication services and for more complex residential treatment in hospital. (Pp. 15)

In the Rush reports, identified shortfalls and gaps that would require more hospital services as follows:

- Acute Intoxication Services (currently, he reports there are none).
- Structured Comprehensive Intervention Services (currently 25.7 per cent of projected need).
- Intensive Complexity-Enhanced Intervention Services (currently 12.1 per cent of projected need) – this would include the hospital day program which is not slated for any enhancement in the plans.
- Hospital/Complexity-Enhanced Residential (currently, he reports there is none).[7]
- and potentially Multifunctional-Residential Support.

Yet the plan is cut hospital program funding and only enhance "community" program funding. Documents produced by the LHIN summarizing the Mayor's Roundtable cherry-picked three statistics from numerous charts, ignoring all the stats that would have supported enhanced hospital programs rather than cutting hospital programs.[8]

It is not clear where the Rush report's population need projections (which are based on an equation that uses a Canada-wide estimation of need for various services per population) have been used in practice in Ontario or elsewhere and whether they have been found to be accurate. The North Bay report is called a "pilot" but it is not clear what has been piloted. It appears that the pilot refers to simply doing the calculations, not to imposing those numbers on real-world health care services. For

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[7] The hospital-administered residential treatment program capacity is conflated with the "community" residential treatment program in all the data in the 2018 Rush report.

[8] NE LHIN slideshow "Addictions Services in North Bay: Mayor's Roundtable on Mental Health and Addictions" September 11, 2019.

example, there is nothing in the reports to explain the difference between the assessed need, according to the model, and the current-day wait lists for the residential programs or what has happened elsewhere if residential programs are dramatically cut in the context of existing wait lists. There is no actual assessment of the needs of the patients on the wait lists for the residential addiction treatment programs in the reports. Though the reports call repeatedly for a more in-depth assessment of the residential treatment programs in the region, neither report actually does that assessment. The call for this further assessment prior to making changes to residential programs appears in a number of places in the reports. In one example, Dr. Rush says, “The WMS and residential programs need to be more closely examined with better regional and provincial comparators for cost, occupancy rates, retention, and criteria for admission and discharge." (pp. 43)

Finally, as noted above, the Rush Reports do not recommend the hospital service closures that are being planned. Far from it. In fact, the Rush report notes:

> “The Regional Mental Health Program is of considerable importance in North Bay, the wider sub-region of Nipissing-Temiskaming, and of the NE LHIN as a whole. Their strong medical and psychiatric capacity and the mix of mental health and concurrent disorder services are of critical importance. The centre also administers the withdrawal management service and the 21-day residential treatment program, both critically important elements of the continuum of care.” Page 39.

Also:

> “There is significant strength in North Bay and the surrounding area with respect to addiction medicine and provision of ancillary support services, including counselling. This includes the methadone nurse at the WMS/residential treatment centre, an important and exemplary model for other WMS services regionally, if not provincially.” Page 39 – 40.

The only actual recommendations in the reports are as follows:

Priority recommendation – Increase resources to Community Counselling Service and Alliance in Sturgeon Falls to increase outreach, case management and system navigation and supports. Community Counselling Service might also be a good candidate organization to sponsor a community WMS outside of North bay, pending success with a pilot in Timmins.

Medium term priority – Enhance bed capacity at North Bay Recovery Home based on its wait time and role in “transitioning people to community recovery following more intensive short-term treatment. Prior to any funding enhancement, however, this program should also be part of a wider review of the residential services in the NE LHIN…”

The recommendations call for a further review and also call for an assessment of ways to “immediately increase the in-house nursing capacity” at the Regional Mental Health Centre.

There is simply no recommendation to close the 29 residential beds plus 2 crisis beds run by the hospital.

The Plan for North Bay's Addictions Services

Current Funding Model

NBRHC (King St.)
29 Residential treatment beds $1.2 million
(this $ includes $700,000 for residential
Treatment beds and 500,000 for a day program)

NBRCH Main Campus
6 WMS Beds $400-$800,000
2 crisis/safe beds $415,000

Planned Changes

$700,000 cut from hospital 29 residential treatment beds, beds closed.

$700,000 to go to withdrawal management services (including mobile and telephone) under Nipissing Mental Health and Housing Support Services*.

$415, 000 cut from hospital program including 2 crisis/safe beds closed and moved to safe bed program run by Nipissing Mental Health and Housing Support Services* + $185,000 new funding to this program.

*Note: the NE LHIN informed us that Nipissing Mental health and Housing Support Services, the North Bay Recovery Home and a peer support network will be amalgamated and the new amalgamated program is the provider organization.

Case Management (no details)

Community Day/Evening Treatment (administered by NBRHC) ($500,000 existing funding)

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