Reconsidering Serious Occurrence Reporting

Introduction

Children's Mental Health Ontario (CMHO) and our members—child and youth mental health (CYMH) agencies who deliver essential mental health services to young people throughout Ontario—appreciate the Ministry of Children and Youth Services' (the Ministry) efforts to engage stakeholders in the development of regulations to support the implementation of the Child, Youth and Family Services Act (CYFSA), specifically with respect to Serious Occurrence Reporting.

In this document, based on consultation with our members, we have responded to most of the questions from the Ministry's Discussion Guide. However, we begin by articulating an overarching concern with the Serious Occurrence Reporting system, which has been loudly voiced by our members. Namely, that this system is not transparent, and that the goals and motivations that undergird the system are unclear.

CYMH agencies serve children and youth with the most significant and complex mental health needs. These needs often manifest themselves in a wide-range of challenging externalizing behaviours. With this context in mind, it is important that incidents that require the completion and submission of a Serious Occurrence Report (SOR) should not be seen as indications that an agency is acting inappropriately or failing in its responsibilities. Rather, given the clients they serve and the capacity limitations they face, SORs should be viewed as an indication of where agencies need support, and where we can collaboratively work toward improving service planning and delivery, to better meet the needs of children, youth, and families.

We thank the Ministry for our inclusion in this process, and request that we continue to be engaged as the regulations are developed.

Redefining and Recommunicating the Purpose of Serious Occurrence Reporting

Reflecting on the Current Purpose of Serious Occurrence Reporting

CYMH agencies appreciate the importance of informing the Ministry about serious incidents; an effective process for reporting and monitoring such incidents can allow for risk assessment and management, and for planning responses to mitigate risk.

Within the current system, completing and submitting SORs and Annual Summary and Analysis Reports is time-intensive. This is particularly burdensome in a sector that faces significant resourcing issues and has extremely limited capacity. Serious Occurrence Reporting has minimal internal value for an agency, as it has no obvious purpose or use beyond reporting to the Ministry. And agencies also don't have a clear understanding of the ways in which the Ministry values or uses SORs and the corresponding data, beyond risk management. (As far as we know, the Ministry does not have a formal policy position on why Serious Occurrence Reporting is a

requirement, which might help to provide clarity.) So, agencies continue to engage in this work—and are being asked to consult on the process—without having a complete understanding as to why.

Importantly, this is not to say that agencies question that there could be value in Serious Occurrence Reporting. Rather, the concern is that it is not clear how the Ministry uses and values this work, and whether the potential value of this process is being actualized.

Our members tell us that agencies typically only receive responses to submitted Serious Occurrence Reports (SORs) and Annual Summary and Analysis Reports in cases where the Ministry requires further information or if an error in completing a form has been identified. In effect, considerable time is invested in Serious Occurrence Reporting, but any opportunities for the Ministry and agencies to work together to learn from SORs, and improve services accordingly, are lost.

As such, we feel it is important that this document be framed within the perspective that the all parties—including the Ministry, agencies, and children, youth and families—would be well-served by the Ministry redefining and recommunicating the purpose of Serious Occurrence Reporting. Why are we collectively engaged in this process? What should we be aiming to achieve? And what would a new Serious Occurrence Reporting system, that could allow us to successfully achieve these aims, look like? Of course, it is important that any efforts on the Ministry's behalf to reconsider the Serious Occurrence Reporting system and answer these questions be undertaken in collaboration with CYMH agencies, and other relevant service providers.

Potential Uses of Serious Occurrence Reporting

In response to the first CYFSA Discussion Guide, CMHO noted that the CYFSA makes an effort to further accountability, but does so by bolstering existing oversight mechanisms and creating news ones, through various inspection and investigative powers. We appreciate the value of inspections and investigations. However, as we have stated, these measures will be insufficient for enhancing accountability and quality in a meaningful way, as their focus is on identifying problems and not to contributing to a plan for how services can be improved. Likewise, we worry that Serious Occurrence Reporting will continue to be used simply as a mechanism for problem identification.

Of course, a redefined Serious Occurrence Reporting system could serve as an input into broader efforts to improve the quality of services, service planning, and our responsiveness to identified gaps. For example, the use of physical restraint—which requires the completion and submission of an SOR—is a last resort used by CYMH agencies, in cases where it is necessary in order to maintain the safety and security of the client, other clients, and staff working with them. If SORs from a given agency indicate a problematic pattern of physical restraint use, this could serve as an indicator of where an agency may need support. Perhaps a lower client–staff ratio is required, given the complexity of needs exhibited by clients. Perhaps serious incidents are a product of not having enough clinical staff, and / or not having the right interprofessional mix of staff, leaving the agency unable to consistently engage in effective treatment planning.

As such, in addition to redefining and recommunicating the purpose of Serious Occurrence Reporting—and determining how it can serve as an effective input into quality improvement efforts—it is important that there

are also commitments made in policy or regulations that the Ministry will collaborate with providers in improving quality more robustly, through comprehensive quality measurement, evaluation, and planning. And, funding must accompany efforts to address quality, given that underfunding over the course of the last 25 years is a primary driver of the sector's inability to deliver the level of quality that is necessary to meet the needs of children, youth, and families. Without such commitments, we will continue to identify the problems in the child and youth mental health system, without taking the action needed to make services better.

We have attempted to answer many of the questions outlined in the Discussion Guide. But, the best answers to the questions in the Discussion Guide—at least in many cases—hinge on how we conceive of what the Serious Occurrence Reporting system should be seeking to achieve. CMHO and our members would be very eager to engage in discussions with the Ministry on these foundational questions about the purpose of Serious Occurrence Reporting, and hope to have the opportunity to do so.

Responding to the Discussion Guide

Purpose of Serious Occurrence Reports

What are some of the current challenges and opportunities with the existing serious occurrence reporting requirements?

In addition to the foundational issues already outlined, CYMH agencies have identified a range of practical challenges with the current Serious Occurrence Reporting system. Many of these challenges are addressed in response to other questions from the Discussion Guide, but in broad terms, these are issues related to a lack of clarity with respect to Serious Occurrence Reporting requirements. For example, it has been highlighted that there is a need for clearly articulated guidelines for completing SORs, including criteria to determine what counts as a "serious occurrence"; what counts as one versus multiple serious occurrences; what to do when there are multiple providers or multiple funders involved; how much information should be reported, etc.

How can the ministry improve support to service providers and help them better understand the importance of the information being collected, and the various uses/purposes of an SOR once it has been submitted? For example, operational policies such as but not limited to SOR Directives and User Guides.

As stated earlier, we feel it is important that the Ministry redefine and recommunicate the purpose of Serious Occurrence Reporting, so that agencies understand the fundamental reasons for their ongoing engagement in this work. Notably, though the current system is not built as such, a core reason for an improved Serious Occurrence Reporting system could be to inform quality improvement efforts.

For example, we know that escalations and dangerous behaviours are reduced through good behavioural formulation, awareness of trigger events, and early intervention based on treatment plans. Within a revised system in which Serious Occurrence Reporting is used to feed into a quality improvement system, SORs could be used alongside other data to track the use of individualized plans and analyze how the use of such plans—and fidelity to these plans—can be effective in limiting serious occurrences, and in being able to manage such incidents effectively when they do occur. Subsequently, if patterns are identified to suggest a given agency is

struggling to effectively formulate or facilitate treatment plans, the Ministry could assist the agency in trying to determine what challenges they are facing that are preventing them from successfully engaging in this work, and what support they would need to improve their efforts.

Additionally, in terms of the sorts of practical tools highlighted as examples in this question, here are a range of supports that may be useful to agencies:

- Training provided by the Ministry on how agencies are to be completing and submitting SORs.
- A catalogue of examples of various incidents, highlighting what counts as a serious occurrence, guidance on how to handle various situations, guidelines on how to properly complete SORs, etc.
- A glossary of key terms, with an explanation of what is meant relative to each term.
- A Community of Practice, to promote the sharing of ideas and lessons learned among agencies.

Definitions

The CYFSA defines "service provider" and "agency". What additional information or clarification would support all those who are required to report SORs clearly understand that the requirement applies to them?

Even where CYMH agencies know that they are required to submit SORs generally speaking, there are cases where it is unclear if they are required to submit an SOR in a particular instance—specifically in circumstances with multiple partners or various funders. For example:

- If there is an incident that would count as a serious occurrence by the Ministry, but it occurs within the context of a program or service that is funded entirely through non-government sources of funding (e.g., philanthropic fundraising), is an agency required to complete and submit an SOR?
- If there are multiple government-funded service providers sharing the care of a client, and jointly involved in the care and supervision of the young person when a serious occurrence takes place, who is the provider responsible for completing and submitting an SOR?
- If a client is receiving care within the context of multiple programs at an agency when a given incident takes place, and those programs are funded by different ministries, to which ministry or ministries must an SOR be submitted?

Notifications and Timelines

Are there areas of serious occurrence reporting that could benefit from more prescriptive requirements and/or direction from the ministry?

Again, within the broader context of an effort from the Ministry to redefine and recommunicate the fundamental goals of Serious Occurrence Reporting, more clearly articulated reporting guidelines and requirements would be welcomed. Specifically, CMHO members have identified a range of issues, including:

- There are not currently criteria to determine whether an incident warrants the Ministry's awareness and attention; if developed, such criteria could be the basis for determining whether an incident should count as a serious occurrence, and be documented in an SOR.
- There is inconsistency in expectations and interpretations amongst Ministry program supervisors; at times (depending on the regional supervisor), the interpretations or expectations appear to be contradictory to Ministry direction.
- If a prospective client is going through the intake process, but has not yet engaged in a formal service provided by an agency, should the agency file an SOR if an incident occurs involving this prospective client (e.g., a youth alleges abuse during intake)?
- In cases where there are several consecutive incidents involving a client, within close proximity to one another, it is not clear what counts as a single occurrence—to be documented in one SOR—or as multiple occurrences—documented over multiple SORs.

Should there be a requirement for the ministry to receive serious occurrence information from service providers other than residential licensees (such as but not limited to foster care and other placements made by agencies that the ministry does not fund directly)?

In the absence of the sort of reconsideration of the purpose of Serious Occurrence Reporting discussed earlier, this is a difficult question to answer. Unless there are concerted efforts made to better define and identify the purpose of the Serious Occurrence Reporting system, and clarity is provided about how this information is used, expanding the use of SORs to other contexts will further burden these other service providers with an additional reporting mechanism—one which is not linked to outcomes—while not contributing meaningful value to enhancing service planning or quality improvement efforts. But, within the context of a redefined system in which SORs serve as an input into quality improvement efforts, there may be good reason to collect SORs from a range of service providers delivering care and treatment to children, youth, and families.

Are there circumstances where a service provider should be exempted from submitting a serious occurrence report?

Agencies need more flexibility to use their discretion in determining whether a case ought to count as a serious occurrence. For example, at least in cases where a given young person is not considered high-risk, if a young person is temporarily AWOL or is late for curfew, or if a neighbor complains that a young person dropped garbage on their property or was too loud coming home at night—these instances should not necessarily be considered serious occurrences. Such cases may be good examples of when an exemption may be appropriate.

Relatedly, there are serious circumstances where a delay in reporting may be appropriate, and exceptions to the mandatory reporting timelines should be allowed. For example, if staff are simultaneously dealing with the incident, serving other clients, and trying to stabilize other situations, completing and submitting an SOR may reasonably be the lowest priority. Of course, these instances are likely rare, but they may be appropriate grounds for exceptions to meeting the prescribed timelines.

Content

What kind of information should be included in SORs that would assist with improving outcomes for children and/or young persons (e.g. youth perspective)?

We fully endorse efforts to improve the experience and outcomes of clients. As noted earlier, a core reason for Serious Occurrence Reporting could be to inform quality improvement efforts, so that we are continually working toward improving the experiences and outcomes of children, youth, and families. However, we remain concerned that, within the context of the current system, SORs are not an effective tool for this.

With reference to the example highlighted in this question, the existing timeline requirements for submitting SORs following an incident interferes with agencies' ability to capture the youth perspective. In purely practical terms, there simply may not be an appropriate time to do so, in which the young person has been given the opportunity to reflect and provide a considered perspective on the incident. CYMH agencies have protocols in place to ensure that there is a full debrief with the youth involved, at a time appropriate to do so at some point after the incident. Agencies consider these conversations to be extremely important and are often tied to the client's treatment plans. Yet agencies question the value of attempting to capture these conversations within an SOR, at least given the current format on an SOR.

What information do you think would be helpful to you or to the ministry to support increased transparency and accountability respecting SORs?

We have put forward a position earlier in this document with respect to foundational issues with the purpose of the Serious Occurrence Reporting system, which we believe covers this question in some respects. But it should be emphasized that, however the system is to carry on, it is important that agencies receive further communication from the Ministry to understand how SORs are being used. A significant amount of clarity needs to be provided given the wide range of challenges and confusion that currently exist. If SORs are being used as a method of performance evaluation, and if the Ministry believes that agencies are performing poorly based on data from SORs, then agencies must receive feedback, follow-up, and support from the Ministry so that they have the ability to address these issues.

Reporting to the Ministry or Other Entities

What information, if any, from SORs should be available to other entities (e.g., advocacy groups, racialized communities, and individual First Nations, Métis, or Inuit communities)?

In principle, CYMH agencies are supportive of increased transparency, and information-sharing with other sectors, and the public. However, there are a range of concerns about why SORs would be used as the basis of this information. Questions arising include:

- Would there be a way to properly communicate the context, so that partners and the public could understand what the data means? If not, is there a risk of agencies being subject to public criticism, based on a misunderstanding of the data, making agencies hesitant to report in some cases?

- Because of the range of challenges articulated earlier with respect to a lack of common understanding about the Serious Occurrence Reporting system, there are concerns about the variability SORs; it might appear that there is consistent data, when it is actually "apples and oranges."
- Different agencies serve very different client populations in some cases. The number and nature of SORs at a given agency may appear problematic, even if it is more actually a reflection of a particularly challenging client population—who have intensive mental health needs—and / or that that agency requires more resources or staff or supervision or training to better serve its clients.
- There are also privacy implications to making this data available, which require significant consideration.

Should the regulations identify specific information required to support the Annual Summary and Analysis Report? Can you provide examples for consideration?

As discussed, it is not clear how the Annual Summary and Analysis Report is used by the Ministry. Before agencies comment on what specifically should be included in these reports, the sector would like to better understand the report and why this information is being collected in the first place.

Conclusion

CYMH agencies appreciate the importance of informing the Ministry about serious incidents; an effective process for reporting and monitoring such incidents can allow for risk assessment and management, and for planning responses to mitigate risk. However, beyond this, agencies don't have a clear understanding of the ways in which the Ministry values or uses SORs and the corresponding data.

As such, we have attempted to respond to the questions from the Discussion Guide from the perspective that all parties would benefit by the Ministry redefining and recommunicating the purpose of Serious Occurrence Reporting, and exploring opportunities for how Serious Occurrence Reporting could serve as an input into broader efforts to improve the quality of services, service planning, and our responsiveness to identified gaps.

Otherwise, considerable time will continue to be invested in Serious Occurrence Reporting, without capitalizing on opportunities for the Ministry and agencies to work together to learn from SORs, and improve services accordingly.

We thank the Ministry for our inclusion in this process, and request that we continue to be engaged as the regulations are developed.