



**SMOOTHING THE PATH:
Addressing Alternate Level of Care
Issues for People with Severe
Behaviour Issues including Dual
Diagnosis**

Final report

**Prepared by:
The Mental Health and Addictions
Alternate Level of Care Advisory Committee**

September 30, 2011

*SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People
with Severe Behaviour Issues including Dual Diagnosis*

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Dear Camille,

Thank you for the opportunity to lead an initiative addressing Alternate Level of Care issues for people with behavioural challenges and dual diagnosis. With the support of your staff, a group of experts with years of experience in the field developed an action plan. On behalf of each member of the Mental Health and Addictions Alternate Level of Care Advisory Committee, I am pleased to submit our final report: SMOOTHING THE PATH. The accompanying document describes the process for the initiative and outlines specific recommendations.

The recommendations provide short, medium and long-term opportunities to improve patient and family experience, and to optimize system alignment and flow. The report also highlights service resource gaps – particularly for high support housing – and the importance of investment in specific areas.

I would like to thank the Toronto Central LHIN for its leadership in sponsoring this project and for ongoing support for the effort. I would specifically like to thank Andrea Demers of the Program Development Team at the Toronto Central LHIN for her support and guidance throughout the process. I would also like to thank the many individuals who took the time to share their ideas, information, passion and commitment to the work of the initiative.

I look forward to continuing our work together on this most important issue and to supporting the implementation of the recommendations that have been made.

Sincerely,

Dr. Catherine Zahn
President and Chief Executive Officer
The Centre for Addiction and Mental Health

Dedication

We would like to dedicate this report in memory of Manuela Dalla Nora. Manuela was the Executive Director of Vita Community Living Services and Mens Sana: Families for Mental Health and an inspiring member of the Advisory Committee. She passed away midway through the development of this report. Manuela's death is a tremendous loss– to her family and friends, her organization, and to all the communities and sectors in which she worked over her exceptional career. She was a strong, passionate and caring leader, always focused on trying to make a positive difference in the lives of people with developmental and psychiatric disabilities. We hope that the work we had to complete without her, lives up to the high standards that she set.

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EXECUTIVE SUMMARY

In February 2011, the Toronto Central LHIN (TC LHIN) contracted with the Centre for Addiction and Mental Health (CAMH), with support from a cross-sectoral Advisory Committee to:

- 1) Transition 30 long-stay Alternate Level of Care (ALC) patients with severe behavioural issues and dual diagnosis from TC LHIN hospitals to a more appropriate level of care
- 2) Develop a framework and comprehensive plan for the ongoing care and management of individuals with severe behavioural issues including dual diagnosis in the TC LHIN; and
- 3) Address issues surrounding the care of seniors with mental illness and addictions through the health continuum.

SMOOTHING THE PATH: Addressing Alternate Level of Care issues for people with severe behavioural issues including dual diagnosis was developed under the guidance of the Mental Health and Addictions Alternate Level of Care Advisory Committee. The Committee provided strategic direction to and feedback on the project deliverables. Recommendations were also received from the participants of a specially scheduled Seniors Think Tank which was convened early in the process to identify strategies to better support seniors with mental health and addictions needs.

Definition of the target population

The target population for the MHA ALC initiative is people age 16 years and older who demonstrate severe, complex and challenging behaviours (including people with a dual diagnosis), who are at risk of being or have been admitted to hospital, and who once there, are at risk of being or have been designated as requiring ALC. Examples of severe, complex and challenging behaviours include:

- Self-injurious behaviours
- Fire-setting
- Chronic impulsivity, unpredictability and demonstration of lack of judgment
- Frequent, serious inappropriate sexual behaviours
- Frequent wandering and exit-seeking
- Severe aggression including threatening verbal outbursts
- Active substance abuse
- Ongoing verbal outbursts (e.g., continuous calling out)
- Unsafe smoking

These behaviours may be characteristic of the following conditions:

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- Severe and persistent mental illness and addictions
- Dual diagnosis (i.e., mental illness and developmental disability)
- Cognitive impairment unrelated to a developmental disability (e.g., acquired brain injury) but resulting in similar functional limitations, behaviours and needs
- Dementia

Any of these conditions can be accompanied by medical conditions and/or medication management issues and can cause people to be a risk to themselves and/or others.

Transition of identified long-stay ALC patients

In the summer of 2010, prior to the start of this project, 30 individuals were identified by the Toronto Central CCAC as long-stay ALC, requiring transition to a different level of care. As of August 30, 2011:

- Three (3) patients – one (1) each from CAMH, Toronto Grace Health Centre, and Bridgepoint Health – were removed from the list by their physicians due to unstable health conditions or safety concerns
- Fourteen (14) patients were discharged to more appropriate settings
 - Eight (8) from Bridgepoint Health
 - Five (5) from CAMH
 - One (1) from Toronto Grace Health Centre

The remaining patients fall into the following broad categories:

- Those with challenging behaviours who are considered too dangerous to manage outside of an institutional setting (e.g., history of arson and/or manslaughter)
- Those with severe autism, for whom no community living options presently exist
- Those who are unwilling to move, or whose families do not want them to move (including those selecting one Long-Term Care Home (LTCH), or locations with long wait lists)
- Those waiting for high-support housing
- Those waiting for placement in a LTCH where the level of care required to address both their complex physical and mental health/developmental needs is in short supply

Work continues at Bridgepoint Health and CAMH to secure transition opportunities for the remaining 13 patients (11 who remain at CAMH and 2 who remain at Bridgepoint Health).

Through its work to transition the identified patients and conduct an assessment of the current state, the Advisory Committee identified a number of systemic barriers preventing or slowing a

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person's transition to their next level of care. These barriers, to be addressed through the development and implementation of a framework and comprehensive plan for the ongoing care and management of individuals with severe behavioural issues including dual diagnosis in the TC LHIN, include:

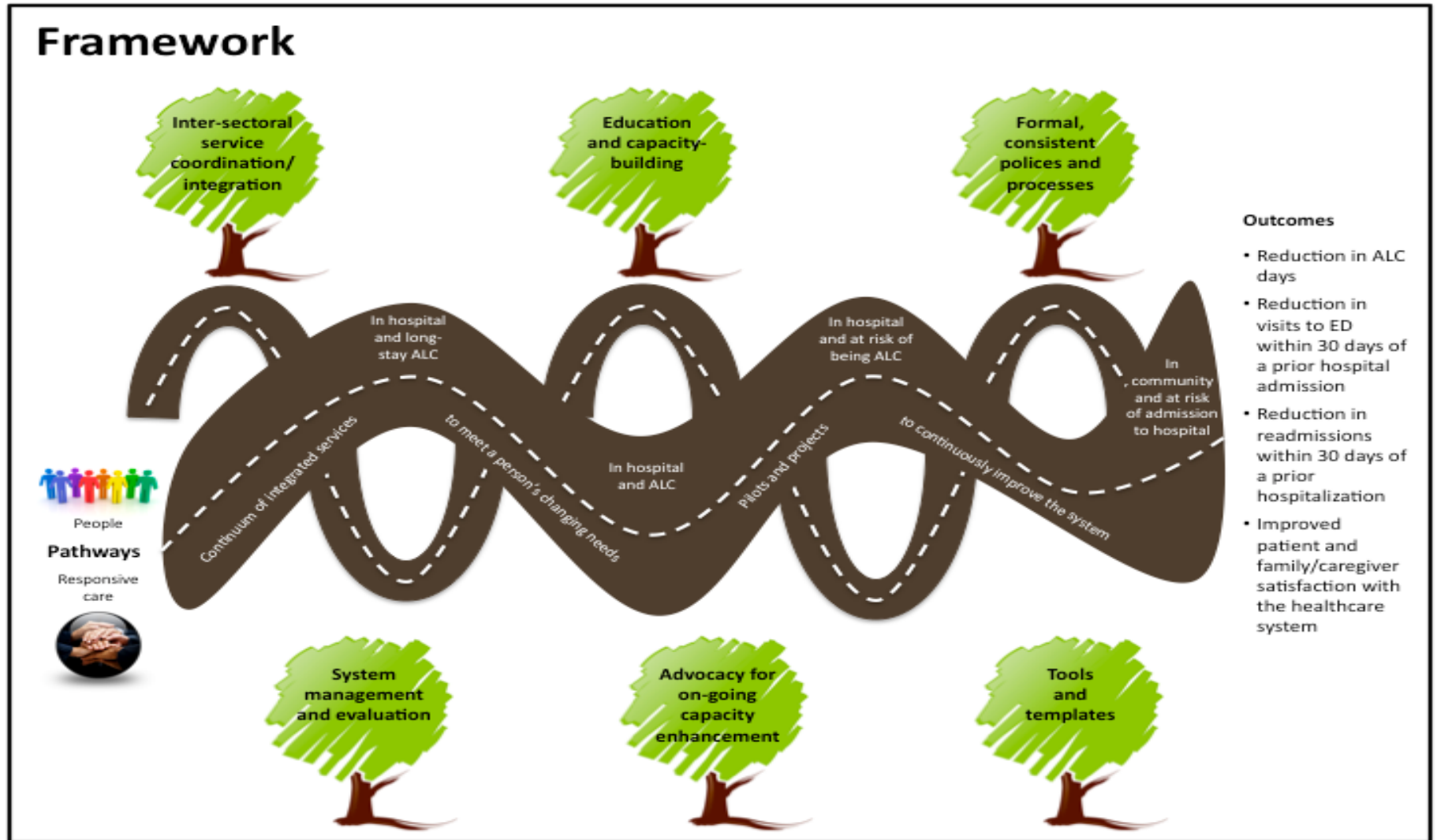
- Suboptimal inter-sectoral collaboration, integration and support
- Insufficient skills, confidence or staffing on the part of receiving care settings
- Inconsistent adherence to established policies, practices, processes
- Patient/family unwillingness to move
- Insufficient supply of high-support housing
- No appropriate ALC location exists (i.e., the individual should not be considered ALC)

Framework and comprehensive plan

The Advisory Committee's recommended framework is shown in Figure 1. The framework is comprised of four key components:

- **Continuum of care:** People designated ALC or who are at risk of being designated ALC need access to a comprehensive continuum of integrated services to meet their needs over time. This continuum should evolve over time based on the evaluation results of pilots and projects that are launched to continuously improve the system. The needed continuum of care is extensive and complex as it is actually a *combination* of four often separate care continuums: the mental illness, addictions, dual diagnosis, and seniors services care continuums. The Advisory Committee identified 32 service categories to be included in the recommended continuum of care. Seven service categories were identified as being in *particular* need of attention:
 - Intensive case management
 - Psychogeriatric outreach services
 - Schedule 1 inpatient services
 - Supportive housing (mental health)
 - Residential supports (dual diagnosis)
 - Residential settings (seniors)
 - Specialized inpatient services

Figure 1 – Framework



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- **Pathways and transition processes:** No matter where people are along their care and recovery journey, there should be a clear pathway and high quality discharge and transition planning process in place to support them to get to their appropriate level of care. The Advisory Committee focused on the development of pathways to address the following situations:
 - The person is in hospital and at risk of being designated ALC (Figure 2)
 - The person is in the community and at risk of admission to hospital (Figure 3)

Fundamental to enabling people to move successfully through the “person in hospital” pathway is implementation of a high-quality discharge and transition planning process. The Committee identified 5 key components comprising such a process. These include:

- Early identification of individuals at risk for being ALC
- Ongoing assessment (with fast-track access to supports when needed)
- Discharge planning (which takes place early in a person’s hospital stay, is ongoing, and viewed as integral to care plan development)
- Transition agreement/contract development
- ALC surveillance/management (including quality and accountability structures)

The Advisory Committee then reviewed the **draft** discharge planning framework and checklists developed by the TC LHIN Discharge Planning Steering Group. The Advisory Committee supports use of the Discharge Planning Steering Group’s draft discharge planning framework and checklist for unscheduled (and scheduled, when they do occur) admissions, subject to some tailoring of the framework and checklists to increase their match with the Advisory Committee’s key process components and their applicability to the Committee’s target population (the specifics of which are outlined in this report).

- **Components needed to make it all work:** People with severe behavioural issues, including dual diagnosis, rarely have linear, easily predictable care and recovery journeys. It is expected that people will make steps forward and then have setbacks from which they must recover over time. Nevertheless, there are some components that if in place, will help smooth and keep people on their individual recovery and potential maximization paths. These components include:

Figure 2 – Person with severe behavioural issues including dual diagnosis is in hospital and is at risk of being designated ALC

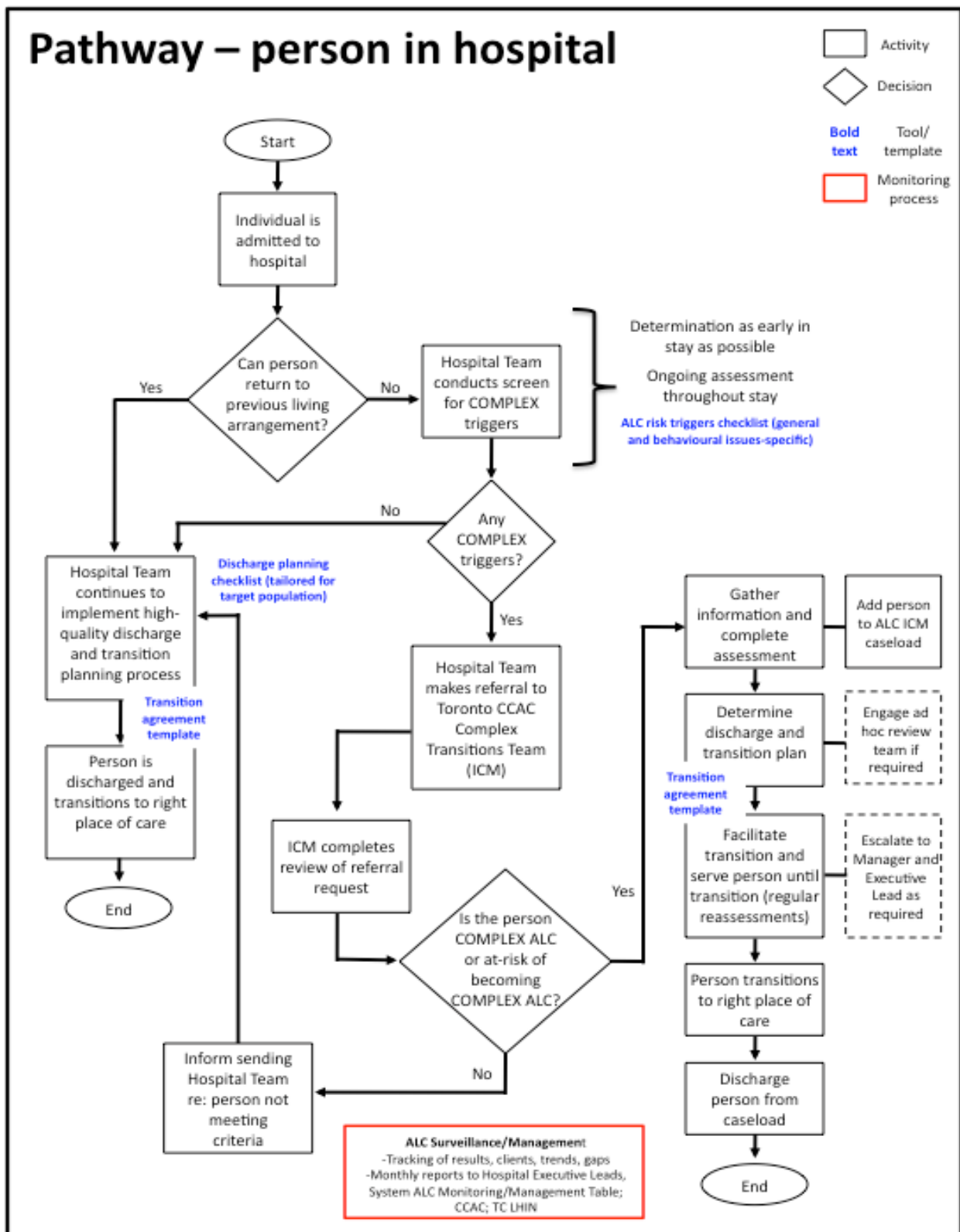
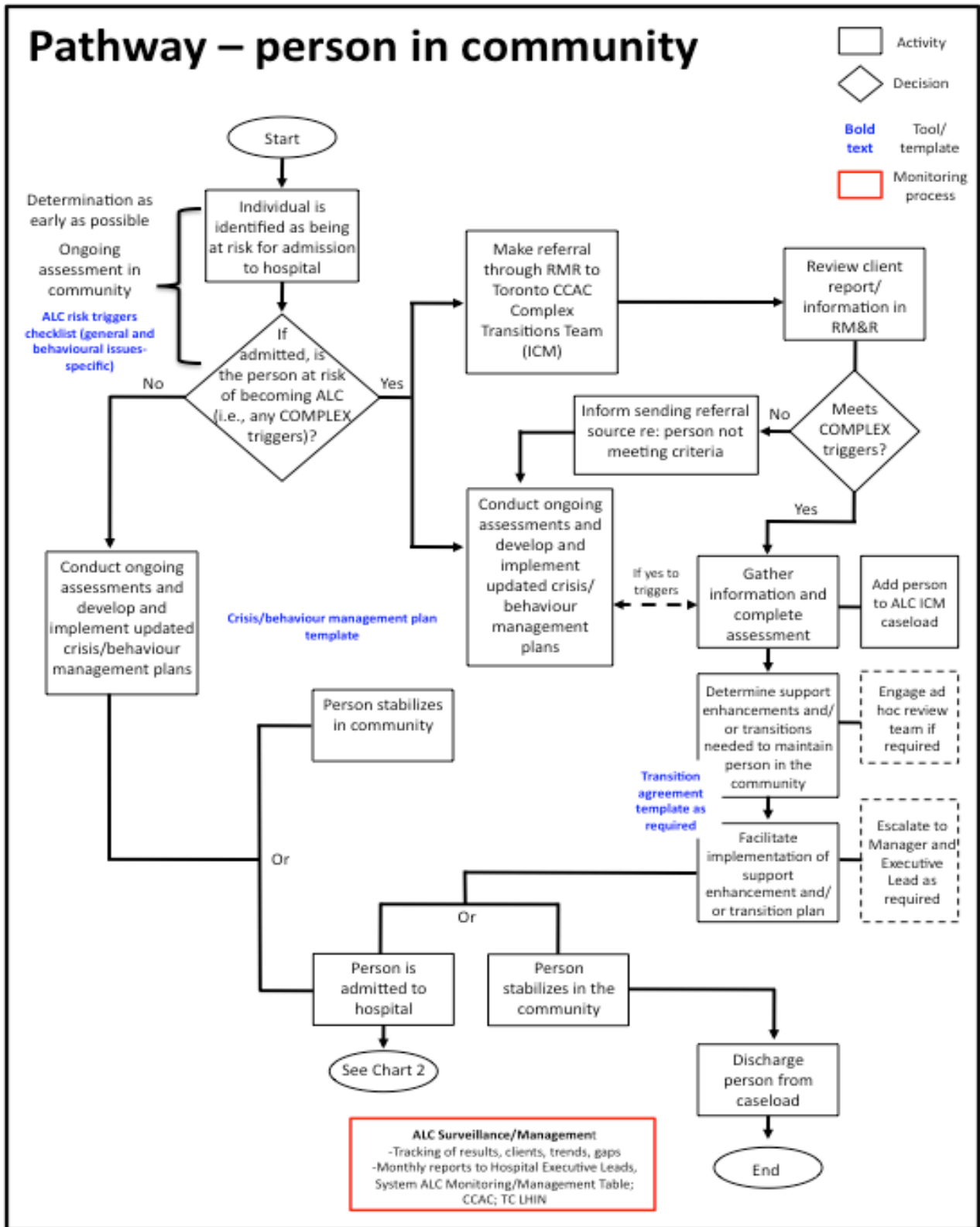


Figure 3 – Person with severe behavioural issues including dual diagnosis is living in the community and is at risk of admission to hospital



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- Inter-sectoral service coordination and integration
- Education and capacity-building
- Formal, consistent policies and processes
- System management and evaluation
- Advocacy for ongoing capacity enhancement
- Tools and templates

These components are represented within the framework as trees, both stable and enduring, but also able to bend and flex in response to changing conditions and needs.

Outcomes: With implementation of the recommended framework, people with severe behavioural issues and needs, including dual diagnosis, will be better able to advance on their recovery and potential maximization journeys. Enabling this will result in four key individual- and system-level outcomes to be achieved, which include:

- Reduction in ALC days
- Reduction in visits to the Emergency Department within 30 days of a prior hospital admission
- Reduction in readmissions within 30 days of a prior hospitalization
 - Reduction in readmissions within 6 months and 1 year of a prior hospitalization (trial indicator)
- Improved, patient and family/caregiver satisfaction with the healthcare system

Recommendations

The Advisory Committee developed one overall and component-specific recommendations that if put in place, will keep people on their individual recovery and potential maximization paths.

Overall

RECOMMENDATION 1:

Adopt and support implementation of the recommended framework (i.e., continuum, pathways and transition processes) for the ongoing care and management of individuals with severe behavioural issues including dual diagnosis in the Toronto Central LHIN.

Lead: Toronto Central LHIN

Timing: Year 1, as soon as possible following review of this report

A. Inter-sectoral service coordination and integration

RECOMMENDATION 2:

Develop five inter-sectoral partnerships that increase the system's capacity to better accommodate and meet the needs of people with severe behavioural issues including dual diagnosis.

- Establish a specialized behavioural needs unit in the Toronto Central LHIN¹.

Lead: Centre for Addiction and Mental Health (CAMH), in partnership with a Long-Term Care Home located in the Toronto Central LHIN and the Toronto Central CCAC

Timing: Year 1, within 6 months, as a demonstration project of the province's Behavioural Support Strategy.²

- Enhance the capacity of an existing Geriatric Mental Health Outreach Team (GMOT) to increase the amount of specialized behavioural support provided to Long-Term Care Homes and expand the age mandate of GMOTs to include people in their 40s-50s with similar need profiles as their current target population.

Lead: Centre for Addiction and Mental Health (CAMH), in partnership with a GMOT located in the Toronto Central LHIN

Timing: Year 1, within 6 months, linked to the initiative outlined above, again as a demonstration project of the province's Behavioural Support Strategy.²

- Collaborate with the Ministry of Community and Social Services (MCSS), Toronto Region to enhance the developmental services system's capacity to support 4 individuals with dual diagnosis in high-support settings.

Lead: Toronto Central LHIN and MCSS Toronto Region, in collaboration with the Toronto Network of Specialized Care and the Developmental Services Toronto Service Providers Committee

Timing: Year 1, within 6 months

¹ A recommendation to support the creation of additional behavioural units in the Long-Term Care sector was also made by the participants in the Multi-Stakeholder Seniors Think Tank held on April 14, 2011.

² The Advisory Committee recommends strongly that this recommendation be implemented as a demonstration project of the province's Behavioural Support Strategy. The Advisory Committee should remain involved in an oversight role through the project's implementation so as to not create additional silos within the system through the launch of independent, unlinked initiatives.

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- Determine whether there are (and if yes, develop a process to capitalize on) opportunities to increase flow through the sector's high-support housing settings through the creation of "step-down" opportunities for people currently living in high-support housing who no longer need that level of support.

Lead: High-Support Housing Consortium (which includes representation from high-support housing settings, the Toronto Central LHIN and Toronto Central LHIN hospitals)

Timing: Year 1, within 12 months

- Continue implementation of the CCAC Complex Transitions Team Intensive Case Management (ICM) model across all TC LHIN hospitals with particular emphasis on:

- Ongoing education of and marketing to hospital and community stakeholders as to the Toronto CCAC ALC Complex Transitions Team and available alternate level of care options

- Utilization of the Resource Matching and Referral (RM&R) system to support the referral process all ALC destinations including supportive housing, attendant care, transitional programs and geriatric assessment and treatment programs through the RM&R system

- Development of a partnership and referral relationship with Toronto North Support Services that includes access to a dedicated Short-Term Support Case Manager (1.0 FTE) either at Access 1 or CATCH (depending on the specific characteristics of the population to be served) who would provide continued transition support as needed to ALC patients waiting for access to mental health ICM or Assertive Community Treatment Team services as part of their longer-term community support plans

Lead: Toronto Central CCAC, in partnership with Toronto Central LHIN hospitals and Toronto North Support Services

Timing: Year 1, within 12 months

RECOMMENDATION 3:

Build on and refine three existing inter-sectoral processes to increase inter-sectoral alignment and capacity to better meet the needs of people with severe behavioural issues including dual diagnosis:

- Build on the Toronto Network of Specialized Care's current Service Resolution process to include more formal and standardized mechanisms to highlight and collaboratively address ALC-related and other issues with the Toronto Central LHIN on a regular basis.

Lead: Toronto Network of Specialized Care Service Resolution Committee in collaboration with the Toronto Central LHIN, MCSS Toronto Region and Developmental Services Toronto Service Providers Committee

Timing: Year 1, within 12 months

- Working within the framework of the *Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis*, engage in an inter-sectoral process to align, at a minimum, MCSS and Ministry of Health and Long-Term Care (MOHLTC) / Toronto Central LHIN principles, objectives, outcomes and action plans regarding:
 - The respective roles each has in the provision of clinical care and supports and long-term care and supports to people with a dual diagnosis
 - Development and implementation of integrated corporate and regional service planning and monitoring mechanisms
 - Development of a shared funding methodology, investment plan and accountability process to guide future planning and investment in the sector

Lead: Toronto Central LHIN; MOHLTC; MCSS Toronto Region

Timing: Year 2 and ongoing

- Determine whether and how people who are designated ALC in hospital could be prioritized for access to transitional or permanent supportive housing, when to do so would be more cost-effective from a system perspective.

Lead: Coordinated Access to Supportive Housing Network (CASH) and Toronto Central LHIN hospitals in collaboration with the Toronto Central LHIN

Timing: Year 1, within 12 months

B. Education and capacity-building

RECOMMENDATION 4:

Establish a time-limited cross-sectoral Task Group to gather, refine and facilitate widespread dissemination of standard information and resources³:

- For patients, families and caregivers
 - A standard document that provides standardized information on transitioning from hospital care (e.g., rights, responsibilities, options, processes, resources)
 - A resource inventory that provides accurate information on all of the recommended service categories and constituent services for people with severe behavioural issues including dual diagnosis, as outlined in Section 4.21 of this report⁴
- Service providers
 - As above for patients, families, and caregivers
 - Diagnosis and behaviours-based fact sheets (that include relevant resources and contact information)

Lead: Toronto Central LHIN to designate lead; designated lead to establish and work with the cross-sectoral task group to leverage and enhance materials already under development or in use across the system.

Timing: Year 1, within 12 months

RECOMMENDATION 5:

Partner with the Ontario Telemedicine Network (OTN) to establish an ongoing series of capacity-building education and training seminars with particular emphasis on:

- Enhancing the community's capacity to support seniors with mental health and/or addictions needs; and people with dual diagnosis⁵

³ A recommendation to build on and promote shared resource databases was also made by the participants in the Multi-Stakeholder Seniors Think Tank held on April 14, 2011.

⁴ The Toronto Central CCAC is already developing this service inventory; the Task Group should contribute to this work to ensure that it accurately captures all of the services outlined in the service continuum recommended earlier in this report.

⁵ A recommendation to design education and cross-training programs for a range of stakeholders including families and caregivers, was also made by the participants in the Multi-Stakeholder Seniors Think Tank held on April 14, 2011. The Toronto Network of Specialized Care already has a partnership with the OTN; this partnership should be expanded and enhanced as part of this recommendation.

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- Continued roll-out of programs that provide training on strategies for working with challenging behaviours (e.g., Partners for the Prevention of Aggressive Behaviours program)

Lead: Designated lead as established through Recommendation 4 above.

Timing: Year 2 and ongoing

C. Formal, consistent policies and processes

RECOMMENDATION 6:

Undertake a current state assessment of organizational ALC prevention and management processes relative to the recommended five-stage discharge and transition planning process and the Discharge Planning Steering Group's checklists (once tailored for our target population). Use this assessment to identify opportunities for improvement and to develop and implement plans to capture them.

Lead: Toronto Central LHIN hospitals

Timing: Year 1, within 12 months and ongoing

RECOMMENDATION 7:

Undertake a current state assessment of community organization ALC prevention and management relative to the two components proposed in this report. Use this assessment to identify opportunities for improvement and to develop and implement plans to capture them.

Lead: Toronto Central LHIN Long-Term Care Homes, Community Mental Health and Addiction Programs, and Developmental Services providers that serve people with a dual diagnosis.

Timing: Year 2 and ongoing

RECOMMENDATION 8:

Ensure the existence and widespread awareness of standard review and issue resolution processes for cases when people with severe behaviour issues including dual diagnosis are "bypassed" or "declined" by Long-Term Care Homes or supportive housing providers.

Lead: Toronto Central CCAC (in relation to LTCHs) and CASH (in relation to supportive housing)

Timing: Year 1, within 12 months and ongoing

D. System management and evaluation

RECOMMENDATION 9:

Establish a cross-sectoral System ALC Monitoring and Management Table and Process that is designed and implemented based on the principles of shared responsibility for system outcomes and continuous quality improvement at the program, organization, sector and system level. The system management process should include:

- Accountability and quality improvement structures and processes that:
 - Establish and monitor both outcome and process system targets and metrics in relation to people with severe behavioural issues including dual diagnosis;
 - Ensure clarity around sector and organization roles, accountabilities, targets and performance management and quality improvement processes;
 - Establish and ensure transparency regarding responsiveness targets and quality improvement commitments by sector and organization
 - Ensure clarity around data collection and submission requirements; and
 - Are incorporated into relevant organization and sector accountability agreements
- A Service Trend and Needs Monitoring process that informs ongoing cross-sectoral service planning and investment
- A Service Resolution process for use in situations where all regular discharge and transition planning processes and resources have been exhausted and unsuccessful, with access to a Flexible Fund to address extraordinary situations

Lead: Toronto Central LHIN

Timing: Year 1, within 6 months and ongoing

The System ALC Monitoring and Management Table should be responsible for overseeing the implementation of the recommendations in this report. Reporting in to the Table should be two *time-limited* task groups which include:

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- A Task Group⁶ charged with reviewing and refining the Discharge Planning Steering Group's recommended Discharge Planning Process/Checklist for Unscheduled Admissions to incorporate the additional discharge planning components and tasks outlined in this report (timeframe – within 2 months); and
- The Task Group charged with gathering, refining and facilitating widespread dissemination of standard information and resources on ALC, discharge and transition planning facts, processes and resources to patients, families, caregivers and service providers across the system (Recommendation 4; timeframe – within 12 months)

The System ALC Monitoring and Management Table should also support its sector member representatives to establish and facilitate knowledge-sharing and relationship-building processes and events. Examples include:

- Regular local and city-wide Long-Term Care Home and Hospital meetings to share information, build relationships and conduct joint problem-solving on local and system-level issues.⁷

Lead: Toronto Central CCAC

Timing: Year 1, as soon as possible following review of this report

- Semi-annual Supportive Housing and Hospital meetings to share information, build relationships and conduct joint problem-solving on system-level issues.

Lead: High-Support Housing Consortium in collaboration with CASH and Toronto Central LHIN hospitals

Timing: Year 1, within 12 months and ongoing

- An annual cross-sectoral event focused on sharing education and capacity-building successes (e.g., partnerships, education and training, resources, methods and approaches), challenges, and stakeholder feedback from across the system

Lead: Toronto Central LHIN

Timing: Year 1, within 12 months, annually thereafter

⁶ Comprised of selected Discharge Planning Steering Group and Mental Health and Addictions Alternate Level of Care Advisory Committee (which cross-sectoral membership from the Developmental Services sector)

⁷ For example, modify existing Long-Term Care Home meeting structures and processes to establish a quarterly schedule of local meetings held in months one and two, and a city-wide meeting in month three.

E. Advocacy for ongoing capacity enhancement

RECOMMENDATION 10:

Collaborate with existing networks and system stakeholders to enhance and communicate the business case to key decision-makers, both systematically and opportunistically, for enhanced, sustained investment in high-support supportive housing options, transitional housing options and high-support 24-hour residential settings with integrated clinical services for people with severe behavioural issues including dual diagnosis.

Lead: ALC System Management Table (recommended above) in collaboration with sector groups and committees (e.g., Toronto Network of Specialized Care; Developmental Services Ontario Service Providers Committee; Coordinated Access to Supportive Housing (CASH); High-Support Housing Consortium; the to-be-established city-wide Long-Term Care Home and Hospital meeting table).

Timing: Year 1, within 12 months, and ongoing

F. Tools and templates

RECOMMENDATION 11:

Disseminate the following tools and templates for use by all relevant stakeholders in the implementation of this report's recommendations:

- ALC risk triggers checklists (general and behavioural issues-specific; Appendix J)
- Discharge planning checklist
- Transition agreement template
- Transition agreement development meeting agenda template
- Pathways/flow maps for specific patient situations
 - In hospital, at risk of being designated ALC
 - In community, at risk of hospital admission
- Resource inventory
- Glossary of Terms

Lead: Toronto Central LHIN

Timing: Year 1, within 12 months and ongoing

Resource requirements

The Advisory Committee developed preliminary cost estimates for implementation of the framework and associated recommendations. For pilot projects, costs are provided for six months of operation. The cost to implement the Committee's recommendations on a pilot / 6 month basis is approximately **\$ 1,072,000**. Some pilot projects, once initiated cannot be completely "turned off." In these cases, on-going costs for maintaining what has been initiated were identified. Annualized, the cost to implement the framework and associated recommendations is **\$ 1,955,000**.

Conclusion

Patients with mental health and addiction needs generally, and especially those who demonstrate severe, complex and challenging behaviours, experience long waits in hospital before transitioning to their next level of care, and face significant challenges getting there. This is not an acceptable situation.

Earlier this year, the Toronto Central LHIN contracted with the Centre for Addiction and Mental Health, with support from a cross-sectoral Advisory Committee, to develop a plan to solve these problems.

This report provides an update on the status of patient transitions, outlines the various barriers experienced when attempting these transitions, and provides the Advisory Committee's best thinking as to the short, medium and long-term opportunities to make significant improvements in the patient and family experience during the transition process and to optimize patients' use and flow through the system's resources. This report also acknowledges the scarcity of resources relative to need in some parts of the continuum – particularly high support housing – and the importance of additional investment in these areas.

The Advisory Committee recommends strongly that wherever appropriate, the recommendations made in this report be implemented as demonstration projects and/or be linked with the province's Behavioural Support Strategy. This is to prevent the creation of additional silos within the system through the launch of independent, unlinked initiatives.

The Advisory Committee looks forward to continuing our work together and with the Toronto Central LHIN on this most important issue and supporting the implementation of the recommendations we have made.

1.0 INTRODUCTION

1.1 Background

Alternate Level of Care (ALC) is a term used to describe hospital patients who face barriers to discharge when the level of care provided in an acute care facility is no longer necessary. Patients designated as suitable for ALC for longer than 30 days (“long-stay”) account for 13% of ALC discharges in the Toronto Central LHIN (TC LHIN), and yet represent over 50% of ALC days. This indicates that a small proportion of people account for a large proportion of ALC days.

In the summer of 2010, the Ministry of Health and Long Term Care’s (MOHLTC) *Access to Care Program* commissioned a survey of all Ontario hospitals, requesting information on each patient with an ALC designation of over 40 days. The purpose of the survey was to better understand the number and characteristics of long-stay ALC patients and the factors preventing their transition to a more appropriate level of care. Each LHIN received information collected about their hospitals’ ALC patients.

The TC LHIN established a Long-Stay ALC Task Force to address the problem. One of the Task Force’s recommendations was to implement an Intensive Case Management and ALC Review Model. This task was assigned to the Toronto Central Community Care Access Centre (CCAC). The Toronto Central CCAC worked with a cross-sectoral team to review all of the long-stay ALC patients and ensure that transition plans were developed for discharge to the most appropriate destination.

As a result of this review process, the Toronto Central CCAC also identified patient populations requiring a system-wide approach to their care and transition across the care continuum. In the mental health and addictions context, two groups were identified: individuals with severe behavioural management issues⁸; and individuals with dual diagnosis (mental health needs and developmental disability). The Toronto Central CCAC report noted that there are gaps in resources and specialized expertise to effectively support the care needs of these groups in the community, resulting in ALC designation and delayed discharge. To address the needs of these groups, cross-continuum population-specific strategies that leverage existing

⁸ Please note that in the context of this report, the term “severe” is used to describe a location on a continuum of behaviours that range from non-existent to severe. Use of this term to describe the severity of an individual’s behaviour should always be accompanied by a specific plan to address and mitigate the behaviour and its impact on the individual, his/her care providers and co-residents so as to allow the individual to be supported in the most appropriate and least restrictive setting possible.

expertise, enable effective transition planning, and provide for specialized supports are required.

Building on the momentum established through these processes, the TC LHIN contracted with the Centre for Addiction and Mental Health (CAMH), with support from a cross-sectoral Advisory Committee, to:

- 4) Transition 30 long-stay ALC patients with severe behavioural issues and dual diagnosis from TC LHIN hospitals to a more appropriate level of care
- 5) Develop a comprehensive plan for the ongoing care and management of individuals with severe behavioural issues and individuals with dual diagnosis in the TC LHIN
- 6) Address issues surrounding the ongoing care of seniors with mental illness and addictions through the health continuum, developed through a Think Tank, to be organized and led by CAMH.

1.2 Advisory Committee Mandate and Membership

A Mental Health and Addictions (MHA) ALC Advisory Committee, chaired by Dr. Catherine Zahn, President and CEO of CAMH, was convened to:

- Oversee the transition process for the 30 identified patients;
- Develop and implement a comprehensive plan for the ongoing, care and management of individuals with severe behavioural issues and individuals with dual diagnosis in the Toronto Central LHIN;
- Review and as appropriate, incorporate the recommendations made by the Multi-Stakeholder Think Tank on Seniors with MHA issues designated ALC or at risk of being ALC

The Advisory Committee was accountable to the TC LHIN through CAMH, as project lead. Appendix A provides the Advisory Committee's Terms of Reference.

In keeping with the need to address issues across the continuum of care, Advisory Committee members were recruited to represent the following stakeholders and sectors:

- Consumers
- Families
- Acute care, complex continuing care and rehabilitation hospitals
- The Toronto Mental Health and Addictions Emergency Department (ED) Alliance
- Long-Term Care

- Assisted living
- Supportive housing
- Specialized dual diagnosis services
- Ministry of Community and Social Services - Developmental Services
- Toronto Central CCAC
- Toronto Central LHIN

Appendix B lists the Advisory Committee members.

The Advisory Committee established ad hoc Working Groups as needed to achieve its deliverables, and meeting invitations were extended to relevant stakeholders (i.e., subject matter experts) when agenda items warranted additional perspectives beyond those represented on the Advisory Committee.

1.3 Definition of Target Population

The target population for the MHA ALC initiative is people age 16 years and older who:

- Demonstrate severe, complex and challenging behaviours, including people with a dual diagnosis⁹; who
- Are at risk of being or have been admitted to hospital; and who once there
- Are at risk of being or have been designated Alternate Level of Care.

A person is designated Alternate Level of Care (ALC) by a physician or his/her delegate when s/he is occupying a bed in a hospital and does not require the intensity of resource or services provided in this care setting (Acute, Complex, Continuing Care, Mental Health or Rehabilitation).

1.4 Related Initiatives

A number of initiatives undertaken by the Province of Ontario and the TC LHIN are relevant to and inter-related with the Advisory Committee's work. These initiatives were reviewed by the Advisory Committee and considered in terms of each initiative's scope, likely impact on the number of ALC cases and days, and potential synergies with the Committee's developing framework and recommendations. The initiatives considered by the Advisory Committee included:

⁹ Appendix C provides additional detail on the definitions of developmental disability used in legislation and within the developmental services and dual diagnosis sectors. For the purposes of this document, the term "developmental disability" is defined broadly (i.e., includes intellectual and other developmental disabilities such as fetal alcohol spectrum disorders and high-functioning autism).

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- Province of Ontario:
 - Aging at Home Strategy (MOHLTC)
 - Ontario Behavioural Support Systems Project (MOHLTC)
 - Community Networks for Specialized Care (MCSS)
 - Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis (MOHLTC and MCSS)
- TC LHIN: One of the key objectives of the TC LHIN's Second Integrated Health System Plan is to improve access to and the efficiency of services. The TC LHIN is working to deliver against this objective through a number of initiatives including:
 - Local Pay-for-Performance ER/ALC initiatives
 - Value and Affordability Task Force and its related initiatives
 - Other Long-Stay ALC strategies and plans
 - Discharge Planning
 - Rehabilitation and Complex Continuing Care
 - Ventilated Patients
 - Local Aging-at-Home Initiatives
 - Integrated Client Care Model for Seniors with Complex Mental Health Needs
 - TC LHIN Virtual Ward
 - Coordinated Access to Intensive Case Management (ICM) and Assertive Community Treatment Team (ACTT) Services in the TC LHIN
 - Coordinated Access to Supportive Housing (CASH)
 - Toronto Mental Health and Addictions Emergency Department Alliance's Mental Health Frequent Users Project

Recommended or possible linkages and inter-relationships with the some of the above initiatives are highlighted in the Advisory Committee's Framework and Recommendations, later in this report.

2.0 METHODOLOGY

SMOOTHING THE PATH: Addressing Alternate Level of Care issues for people with severe behavioural issues including dual diagnosis was developed under the guidance of the Mental Health and Addictions Alternate Level of Care Advisory Committee. The Committee provided strategic direction to and feedback on the project deliverables. Recommendations were also received from the participants of a specially scheduled Seniors Think Tank which was convened early in the process to identify strategies to better support the needs of seniors with mental health and addictions needs.

The MHA ALC Plan recommendations were developed by various ad hoc Working Groups established by the Advisory Committee to focus on specific areas. The ad hoc Working Groups were comprised of volunteers from the Advisory Group, other system stakeholders and were assisted by a CAMH staff member, a project consultant and a member of the Toronto Central LHIN.

The transition of the 30 identified long-stay ALC patients was and continues to be facilitated by intra-hospital teams in each of the hospitals currently providing care to the identified individuals. Representatives from each intra-hospital team met periodically to share information and to conduct collaborative problem-solving for transitioning patients. The intra-hospital group is being assisted by the aforementioned CAMH staff member.

More detail on the methodology used for each project component is provided below. Appendix D includes detail on the project's workplan, including deliverables, key activities, timing and responsibilities.

2.1 Transition of Identified Long-Stay ALC Patients

Thirty (30) long-stay ALC patients were identified for transition by the Toronto CCAC. Some of these people were described as having a dual diagnosis and others as having severe behavioural management issues. Seventeen (17) of these patients were at CAMH, eleven (11) at Bridgepoint Health and two (2) at Toronto Grace Health Centre.

An intra-hospital team was established to coordinate transition activities at each of the three locations, with the ongoing support of the Toronto CCAC. Support was also provided by a CAMH Social Worker seconded to work on the Toronto CCAC review and who continued to support transition activities until early August 2011.

An inter-hospital team met periodically to share information and to conduct collaborative problem-solving for transitioning patients. This group also provided regular updates on their

progress to the Advisory Committee and contributed significantly to the development of the long-term MHA ALC Plan.

2.2 Seniors Think Tank

Seniors were identified as a priority population through a gap analysis commissioned by the TC LHIN. A separate Advisory Committee was convened to oversee the planning and implementation of a Think Tank to address issues surrounding the ongoing care of seniors with mental health and addictions. Appendix E provides an excerpt from “*Adjusting the Sails: Strategies and actions for improving the lives of seniors with mental health and addictions issues designated Alternate Level of Care (ALC) or at risk of ALC*”, the final report prepared following the Think Tank and submitted to the TC LHIN.

The Advisory Committee reviewed “*Adjusting the Sails*” and confirmed that the Think Tank’s analysis and recommendations were highly consistent with its own. Areas with the most significant overlap in recommendations are highlighted in the Recommendations section of this report.

2.3 Development and Implementation of the MHA ALC Plan

The Advisory Committee and its Working Groups developed the MHA ALC Plan by following a four-phase workplan which included the following activities:

- **Phase 1: Current state assessment**

- Confirmation of the size of the ongoing (i.e., beyond the 30 previously identified individuals) population of long-stay ALC patients with severe behavioural issues and dual diagnoses
- Review of the current status of those already transitioned (e.g., to identify the characteristics of the transitioned population that predict success and those that present additional barriers to durable transition)
- Review of recent work done in relation to ALC and the target population
- Interviewing of key stakeholders

- **Phase 2: Lessons learned**

- Identification of the lessons learned from those already transitioned, other sector initiatives and patient populations, subject matter experts
- Identification of the key issues to be addressed within the Toronto Central LHIN

- **Phase 3: Development of a comprehensive, sustainable plan**
 - Development of a governing framework that organizes and manages the continuum of services for the target population
 - Development of strategies to address identified issues
 - Development of hospital-based strategies to identify and manage at risk individuals to prevent them from being designated ALC and ensure timely transitions to the most appropriate destinations
 - Determination of the cost of sustainability of care and services for this population
- **Phase 4: Development and submission of a final report**
 - Drafting, review, revision and submission of this final report

3.0 CURRENT STATE AND KEY ISSUES

The Advisory Committee received regular updates on the status of 30 long-stay Alternate Level of Care (ALC) patients identified by the Toronto Central CCAC as the focus for this initiative. The Committee discussed the barriers encountered at each transition attempt, and the lessons learned from each for the longer-term plan. The Committee also reviewed data to confirm the size of the ongoing population of long-stay ALC patients with severe behavioural issues and dual diagnosis, and reviewed recent work done in relation to ALC and the target population. Finally, project team members conducted interviews with key informants and stakeholders and shared their findings with the Advisory Committee to inform their deliberations.

3.1 Transition of Identified Long-Stay ALC Patients

In the summer of 2010, prior to the start of this project, 30 individuals were identified by the Toronto Central CCAC as long-stay ALC, requiring transition to a different level of care. As of August 30, 2011:

- Fourteen (14) patients were discharged to more appropriate settings
 - Eight (8) from Bridgepoint Health
 - Five (5) from CAMH
 - One (1) from Toronto Grace Health Centre
- Three (3) patients¹⁰ – one (1) each from CAMH, Toronto Grace Health Centre, Bridgepoint Health – were removed from the list by their physicians due to unstable health conditions or safety concerns

The remaining patients fall into the following broad categories:

- Those with challenging behaviours who are considered too difficult to manage in the community (including those with a history of arson and/or manslaughter)
- Those with a dual diagnosis and severe autism, for whom no community living options presently exist
- Those who are unwilling to move, or whose families do not want them to move (including those who have selected only one LTCH location, or locations with very long waiting lists)

¹⁰ For the purposes of this document, because many of the people under consideration in this project are people in hospital, the word “patient” will sometimes be used when other phrases such as “people in hospital” or “designated long-stay ALC people” would otherwise be awkward or cumbersome.

- Those waiting for high-support housing, where waiting lists are very long
- Those waiting for placement in a LTCH where the level of care required to address both their complex physical and mental health/developmental needs is in short supply

Work continues at Bridgepoint Health and CAMH to secure transition opportunities for the remaining 13 patients (11 who remain at CAMH and 2 who remain at Bridgepoint Health).

See Appendix F for more detail on the current status of and lessons learned from the identified long-stay ALC patients.

3.2 Size of the Mental Health and Addictions Long-Stay ALC Population

As a first step in developing a comprehensive, sustainable plan for the ongoing care and management of individuals with severe behavioural issues and dual diagnoses, the Advisory Committee attempted to determine is the true magnitude of the problem.

Estimates suggest that over the course of a fiscal year, approximately 700 Mental Health and Addictions ALC patients are discharged from acute care and specialized mental health and addictions unit settings, and approximately 150 of these are discharged having had stays of over 40 days. Long-stay ALC patients with severe behavioural management issues including dual diagnosis account for approximately 26% of the total ALC long-wait patient population. The average length of ALC stay for these 150 people is 77.4 days, with a range of total ALC days between 41 and 255. Currently, the figures do not include Rehabilitation and Complex Continuing Care data, as this data was available at the time of the writing of this report.

3.3 Characteristics and Needs of the Target Long-Stay ALC Population

Through the work of the inter- and intra-hospital transition teams, reviews of recent reports and interviews with key stakeholders, the Advisory Committee developed a profile of the characteristics and needs of the long-stay ALC patients. This profile was used to inform the development of long-term strategies and action plans as part of the overall MHA ALC Plan.

The target population for the MHA ALC initiative is people age 16 years and older who demonstrate severe, complex and challenging behaviours (including people with a dual diagnosis), who are at risk of being or have been admitted to hospital, and who once there, are at risk of being or have been designated Alternate Level of Care.

Examples of severe, complex and challenging behaviours include:

- Self-injurious behaviours
- Fire-setting

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- Chronic impulsivity, unpredictability and demonstration of lack of judgment
- Frequent, serious inappropriate sexual behaviours
- Frequent wandering and exit-seeking
- Severe aggression including threatening verbal outbursts
- Active substance abuse
- Ongoing verbal outbursts (e.g., continuous calling out)
- Unsafe smoking

These behaviours may be characteristic of the following conditions:

- Severe and persistent mental illness and addictions
- Dual diagnosis (i.e., mental illness and developmental disability)
- Cognitive impairment unrelated to a developmental disability (e.g., acquired brain injury) but that results in similar functional limitations, behaviours and needs
- Dementia

In addition, any of the above conditions can be accompanied by significant medical conditions and/or medication management issues, and can cause people to be a risk to themselves and/or others.

Transition and discharge plans are usually as individual as the people themselves, but most include some or all of the following broad strategies:

- **Supervision and monitoring:** Higher levels of supervision and monitoring than are available in most community settings (e.g., accompaniment to appointments and on outings; up to 1:1 or 2:1 coverage during periods of decompensation, 24 hours per day, 7 days per week to prevent injuries to self or others or patient AWOL situations)
- **Physical environment:** Safe physical environments that are tailored to reduce the likelihood of self-harm or harm to others (e.g., use of single rooms or single apartments; availability of secure outdoor space; locking of cabinets containing items known to “trigger” challenging behaviours; construction of walls and floors with highly durable and flexible materials)
- **Social environment:** Social environments and construction of daily schedules that engage clients, encourage healthy interactions, provide meaningful activity, promote recovery to reduce the likelihood of the person’s being exposed to things that are known to exacerbate the challenging behaviours (e.g., use of headphones to reduce noise;

scheduled and time-limited mealtimes; time for physical activities that the person is known to enjoy; scheduled smoking breaks)

- **Staff experience and expertise:** Provision of care and support from service providers trained in working with people who have complex needs and in managing specific behaviours (e.g., engagement; redirection; contracting)

Patients with mental health and addiction needs generally, and especially those who demonstrate severe, complex and challenging behaviours, experience long waits in hospital before transitioning to their next level of care. According to the provincial *Access to Care Program Survey*, 16% of all ALC long-wait cases are waiting in a mental health bed for an alternate level of care. As stated in the report:

“There is a gap in service available for patients with behavioural and psychiatric issues...exit-seeking, wandering and aggressive behaviours are consistently cited as....difficult to accommodate due to the need for increased staffing and secured units.”

*Provincial ALC Long Wait Cases Project
Working Group Meeting #2, August 2010*

According to the *Long Stay ALC Review and Intensive Case Management Project: Final Report* (TC CCAC), dual diagnosis patients represent 23.6% of the patients they reviewed. As stated in the report:

“Managing behaviours in a conventional manner is not always effective due to the developmental disability and can pose a risk to the other residents, due to the patient’s lack of insight. As these patients remain in hospital for extended periods of time, the community settings are not adequately prepared to receive them.”

*Long-Stay ALC Review and Intensive Case
Management Project: Final Report*

It is important to note that that the MOHLTC and Ministry of Community and Social Services (MCSS) have developed joint policy guidelines for the provision of community mental health and developmental services for adults with a dual diagnosis. In addition, both Ministries share a responsibility to work with the Ministry of Children and Youth Services (MYCS) regarding system planning for transitional age¹¹ youth with a dual diagnosis.

¹¹ Transitional age youth are typically defined as youth aged 16-24 years. The Ministry of Children and Youth Services has a specific responsibility to collaborate with the Ministries of Health and Long-Term Care and Community and Social Services in relation to children and youth age 16 and 17 years with a dual diagnosis.

The joint policy guidelines are intended to provide a framework for planning, coordination and delivery of services and supports that will promote better access to both the mental health and developmental service sectors. At the local level, MCSS has funded the Community Networks of Specialized Care to work with local-area LHINs to build linkages across both sectors and their respective services. To access MCSS-funded services, individuals must be assessed by their local Developmental Services Organization (DSO) to confirm the person's eligibility for developmental services.

3.4 Recent Work Upon Which To Build

The Advisory Committee was fortunate to be able to draw upon a significant amount of work done on the long-stay ALC issue. Of note are the following reports:

- The Long Stay Alternate Level of Care (ALC) Review and Intensive Case Management Project in the Toronto Central LHIN: Final Report – Toronto CCAC, January 2011
- From Hospital to Home: The Transitioning of Alternate Level of Care and Long-Stay Mental Health Clients – Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health, September 2009
- Analysis in Brief: Alternate Level of Care in Canada – Canadian Institute for Health Information, January 2009
- Appropriate Level of Care: A Patient Flow, System Integration, Capacity Solution – Provincial Expert Panel on Alternate Level of Care, 2006

Appendix G contains a list of background documents used in the development of the MHA ALC Plan and in the preparation of this report.

A significant number of people have worked on the ALC issue over the last number of years and the Advisory Committee sought their input and advice during the project. Appendix H contains a list of people consulted during the development of this report.

3.5 Barriers to Transition and Key Issues to be Addressed

The Advisory Committee identified a number of systemic barriers preventing or slowing a person's transition to their next level of care. These barriers include:

- Insufficient inter-sectoral collaboration, integration and support
- Insufficient awareness, skills, confidence and/or willingness on the part of receiving care settings

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- Lack of or inconsistent implementation and/or adherence to established policies, practices, processes
- Patient/family unwillingness to move
- Insufficient availability of high-support housing
- No appropriate ALC location exists (i.e., the individual should not be considered ALC)

Each barrier is listed below, together with the issues identified by the Advisory Committee as needing to be addressed in order for the barrier to be removed in support of earlier, easier and better supported transitions in the future.

Suboptimal inter-sectoral collaboration, integration and support

- **Different sector priorities:** There is a lack of clarity as to where ALC fits within the overall set of priorities established by each sector which determine who has priority access to available placements. For example, Developmental Services sector priority populations include “at risk” groups (e.g., youth in the child welfare system who are now adults), individuals whose parents died or are very aged, and individuals currently residing in the sector’s scarce residential treatment beds. Long Term Care Homes and Supportive Housing place priority on placing people who are homeless, such that an individual at the top of the LTCH’s waiting list who is in hospital and designated as long-stay ALC in hospital, can be “passed over” multiple times in favour of individuals who are homeless.
- **Different sector processes:** Each sector has its own processes and systems through which to access services. The Developmental Sector has a community-based process for access to specialized supports, operationalized through the Community Network of Specialized Care. The Supportive Housing Sector has a coordinated access point to a range of housing and support options called Coordinated Access to Supportive Housing (CASH). Long-Term Care Home placements are accessed through the Toronto Central CCAC. These processes are not always well understood across sectors which can result in inappropriate or no referrals to a potentially suitable level of care.
- **Lack of coordination and defined criteria in the Attendant Care, Long-Term Care and Supportive Housing sectors:** Supportive Housing, Long-Term Care and Attendant Care program eligibility criteria are different and the level of care that can be provided is poorly understood and difficult to access. This results in inappropriate or no referrals to a potentially suitable level of care.

Insufficient awareness, skills, confidence or staffing on the part of receiving care settings

- **Lack of knowledge of available placement options and levels of care provision:** There is a general lack of knowledge of the full range of available options within the continuum of care that can result in assignment of both the wrong ALC designation and place of care. There is a lack of clarity around the level of care that can be provided in different settings, different settings' eligibility criteria and the suitability of different settings for various patient populations.
- **Fears of and/or concerns about the risks associated with unsuccessful transitions:** Healthcare team members at some institutions can be reluctant to discharge patients from hospital due to concerns about unsuccessful transitions. This is sometimes a result of their having reduced expectations about a person's ability to adapt to life in a new setting, having only seen the individual in an institutional setting, or their past experiences where transitions have not been successful.
- **Insufficient skills, resources or capacity (real or perceived) to support selected patient populations:** Patients with severe behavioural management issues often experience long waits in hospital as there is no specialized location for the assessment and treatment of these patients and many LTCHs do not have the skill, resources or capacity to support them safely. Patients with mental health and addiction needs and significant behavioural issues can also experience long waits due to the limited capacity in existing transitional programs and long wait lists for affordable and supportive housing. Patients with a dual diagnosis frequently experience lengthy waits as conventional approaches to managing behaviours are often ineffective for patients with a developmental disability. The level of knowledge and capacity to support these patients in LTCHs or in the community is lacking. All of these challenges are compounded if the patient has both medical (e.g., in/out catheterization, feeding tubes) and behavioural management issues and needs.
- **Stigma and discrimination against forensic patients:** Patients in hospital by order of the Ontario Review Board are affected by the powerful stigma and discrimination that exists against people who have been hospitalized for their criminal behaviour. In addition there are a number of complexities that arise when planning for a person's transition that are associated with the need for ORB approval of the person's placement.

Lack of or inconsistent implementation and/or adherence to established policies, practices, processes

- **Lack of consistently implemented early identification, assessment, reassessment and transition management processes:** Within and across most hospitals, there is no consistent process in place to ensure that patients: are identified as early as possible during their hospital stay that they are at risk of becoming ALC; are assessed and regularly reassessed in relation to their ALC designations once they have been deemed ALC; and are moved through a consistently high quality discharge and transition planning process.
- **Lack of timely responses and decision-making:** The involvement of other organizations and agencies in the decision-making process can delay decision-making and patient transitions. For example, situations that require the involvement of the Office of The Public Guardian and Trustee (PGT) are often challenging both in terms of the determination of an appropriate ALC designation and obtaining a timely response for decision-making. Delays in receiving responses from Long-Term Care Homes (LTCH) both inside and outside the Toronto Central LHIN contribute to potentially avoidable ALC days (e.g., regulations require responses within 5 days but can take up to 5 months to receive responses as to a patient's acceptance or decline). Decisions as to a person's acceptance by an organization are often only provided after a lengthy costing process has been completed (as opposed to before the costing process, with the decision being made on the basis of the person's needs and assuming availability of needed resources), which may result in significant time passing and work being only for the person to be declined.
- **Variations in placement assessment and decision-making processes:** At times, an initial review is completed and the patient is accepted, the patient is placed on the waiting list, a space becomes available, and then a more in-depth review is completed which results in the patient being rejected. While this rejection is sometimes warranted due to a changed condition, it can also result because the initial review was cursory or subsequent reviews were not completed accurately, or in a timely way.
- **Insufficient standardization of waitlist management processes or use of service resolution-like mechanisms:** People at the top of a given LTCH's waitlist can be bypassed again and again because of changing needs and circumstances that make them "not ready" when a space becomes available (with no or few review mechanisms to

determine ongoing appropriateness of match given changing needs or problem-solving to ensure person is ready when space is ready or vice-versa).

Patient/family unwillingness to move

- **Legislative/regulatory barriers:** The current Long-Term Care Act (2007) and Regulations can contribute to the number of ALC days as patients are able to wait in ALC status for the Long-Term Care Home of their choice. Patients and/or families who are unwilling to relocate can delay their transition by selecting only one or a small number of options with long wait lists. Patients and/or families who support relocation, may want and wait for only 1-2 LTCH options and/or refuse to either add more choices or consider options with shorter wait lists.
- **Long-term institutionalization:** Long-term institutionalization of some patients has resulted in unwillingness by the patient and/or family to relocate to a more appropriate level of care.
- **Reluctance and/or inability to charge co-payments:** Patient and/or family unwillingness to move can sometimes be caused because it will cost them more money to transition to the new setting. For example, a patient currently in a room for which they do not need to pay in hospital, may have to pay for that level of room in a Long-Term Care Home or for rent in Supportive Housing setting.

Insufficient supply of high-support housing

- **Shortage of high support housing:** Much of the recent expansion of supportive housing capacity has been in the form of scattered units accessed through the private market. While a welcome addition of capacity, multiple reviews of the needs of mental health and addiction ALC patients have indicated the need for more high-support housing. Recently, there have been efforts to create this capacity in the mental health sector and in the developmental sector for individuals with a dual diagnosis (e.g., the specialized treatment beds coordinated through the Community Networks of Specialized Care). However, the existing capacity remains insufficient to meet the demand for this model of housing within the broader range of supportive housing options.
- **Inequitable access to supportive housing resources:** There is insufficient coordination and lack of equitable access to affordable supportive housing resources. Existing centralized access processes (e.g., the Centre for Independent Living in Toronto (PIC Application), Coordinated Access to Supportive Housing (CASH) and Toronto

Social Housing Connections) are not sufficiently coordinated or well-known. Access to supportive housing for people with mental illness and other patients is limited by long wait times. Access to subsidized or rent-gear-to-income housing is equally poorly coordinated.

- **Inequitable access to specialty services:** Non-acute care hospitals, specialty hospitals, LTCHs and community agencies (e.g., attendant care, supportive housing environments) have limited and variable access to specialty services such as psychogeriatric services, psychiatric consultation services, and wound care expertise, and to specialty equipment for patients who are obese or very tall.

No appropriate ALC location exists

- **Lack of appropriate alternate level of care:** In some situations, there does not appear, in the current system, to be a suitable alternative to hospitalization for selected high-needs patients, nor can one be created in the short-to-medium-term that is more cost-effective or appreciably increases the patient's quality of life. In these situations, the patient's ALC designation should be removed.

4.0 FRAMEWORK

The Advisory Committee developed a framework for the ongoing care and management of individuals with severe behavioural issues and dual diagnosis. This framework was developed according to a set of principles established by the Committee. The framework includes description of the organization and management of transitions across the continuum of services for each population group.

4.1 Objectives, Assumptions and Guiding Principles

The Advisory Committee began development of its recommended framework by agreeing on:

- The overall objectives to be achieved as a result of implementation of the framework;
- A set of assumptions about the context within which the Committee was doing its work; and
- A set of principles to which the Committee sought to adhere when developing its recommended framework.

Overall objectives

- Reduce ALC days (i.e., prevent and minimize the number of people and amount of time they spend designated ALC, short- or long-stay);
- Prevent avoidable Emergency Department visits and readmissions; and
- Ensure that the right person is in the right place at the right time to optimize his/her health and recovery.

Assumptions

- ***A lot of work exists upon which to build:*** The Advisory Committee focused on identifying, collating and synthesizing the work that has already been done (e.g., to reinforce the factors that make for successful transitions and embed responsibility for mutual sector change and shared accountability across the system)¹², rather than re-inventing this work in the hope of generating novel solutions to specific system problems. The Advisory Committee is indebted to those who contributed to all of this earlier work.

¹² For example, ensuring a really good and appropriately timed and phased transition plan is in place; ensuring strong assessments of need and matching to appropriate environments; and ensuring the commitment of sending organizations to provide support through and after the transition has occurred as needed – or put another way, ensuring effective agreements between partners; ongoing education and training; and the provision of urgent access to experts when needed.

- **An integrated, cross-sectoral approach is needed:** Severe, complex and challenging behaviours typically result from complex conditions that often require a multi-faceted, cross-sectoral service response from both the health and social services sectors. Similarly, only an integrated “whole system” approach is sufficient to deal with the multi-dimensional nature of the ALC issue.
- **Complex situations need robust, flexible system responses:** What most long-stay ALC patients share is a complexity of individual circumstances and needs, for which a system response has not been developed. Yet if supported appropriately, most people can move forward in their recovery process and remain in the community – “in a better environment, most people do better” said one Advisory Committee member.
- **People must have access to a comprehensive continuum of care that offers a range of service options:** This continuum should be able to provide the least intrusive care possible and include general health services such as primary care, general hospital services, and, for those with complex needs, cross-sectoral services and responses that integrate the expertise and knowledge of the mental health, addictions, developmental services, and seniors sectors.
- **A significant capacity issue will remain:** While implementation of the recommendations in this report will help to reduce ALC days and ensure more people are being supported at the right level of care, there remains a *significant* capacity problem within the system. There is not enough high-support long-term care and supportive housing to meet current needs. If the future volume of ALC designations is to be forever reduced, a concerted, sustained, cross-sectoral effort and investment in high-support long-term care and supportive housing is required. Also needed is ongoing review and expansion of existing and the development of new high-support service models or options.

Guiding principles:

The following principles are intended to apply to and guide the care delivery and decision-making processes of all individuals and organizations involved in serving the project’s target population.

- **Inclusion and equity:** People who demonstrate severe, complex and challenging behaviours, including people with a dual diagnosis, are equal and valued members of society and have the right to dignity and freedom from discrimination. Rather than discriminate against people with severe behavioural issues including dual diagnosis, who

are at risk of becoming or are designated long-stay ALC, health care providers and the system must embrace the opportunity to think differently about how best to meet people's complex, challenging and individual needs. Discrimination against this population is not accepted.

- **Autonomy and choice:** Patient autonomy and choice is to be maximized, within the context of constrained system resources and the frequent need to achieve an appropriate balance among competing system, group and individual needs. This principle applies to all, including those with developmental disabilities, who also have the right to self-determination including the right to make decisions about their lives.
- **Information and education:** People who demonstrate complex and challenging behaviours, including people with a dual diagnosis, are to be provided with information and education about their rights, responsibilities, options and choices in relation to the care delivery and transition processes. This is to be done both when receiving services and when transitioning between levels of care. People and their families must also be educated about how to complain and appeal decisions. All information must be provided in plain, accessible language and translated as needed. While rights and responsibilities education is primarily targeted to people with disabilities, service providers, administrators, support staff and family members must also receive this education.
- **Safety and security:** Patient, family, care-giver, staff and community safety and security must be ensured through provision of the right level of effective, recovery-oriented care and supports.
- **High quality discharge and transition planning:** Patients and their families must be supported by high quality discharge and transition planning, the key components of which include:
 - **Standardization:** Existing discharge and transition planning processes must be standardized to ensure consistent incorporation of the components of high quality discharge and transition planning. Standardization is viewed as an important way to improve on all dimensions of quality, but does not imply standardization of individual care plans or service responses, which must be individualized to best meet the person's unique needs and situation.
 - **Patient and family/care-giver involvement and collaborative decision-making:** There must be maximum appropriate patient, family and care-giver involvement and

collaborative decision-making in the development, implementation and ongoing monitoring of patients' transition plans.

- **Early identification and planning:** Patients at risk of being designated ALC must be identified early and discharge and transition planning must be integrated from the outset into a person's overall care and support plan (i.e., discharge planning is viewed not a point-in-time activity, but as a key component of a person's overall care plan).
- **Access to ongoing assessment:** Patients must have easy and ongoing access to good clinical assessments that inform transition care and support plans that evolve over time in response to people's changing needs.
- **Team- and system-based planning and responses to individual needs:** Inter-agency, cross-sector agreements must be developed and formalized that enable individualized responses to complex and challenging needs. "In situ" interventions are developed and implemented wherever possible, but it is expected that there will be patient movement back and forth across agencies and sectors. This movement must be allowed for and accommodated without penalizing the individual for changes in his/her condition. Handovers of care are particularly high risk and must receive particular focus throughout the discharge and transition planning process.
- **Leveraging of specialized services:** The plans and responses developed to address individual needs should include leveraging of both existing (e.g., Toronto Central CCAC's ALC Complex Transitions Team) and potential new (e.g., behavioural management skill-enhanced Geriatric Mental Health Outreach Teams) specialized services to enhance service providers' capacity to meet the complex needs of the target population, minimize patients' lengths of stay in inappropriate settings (wherever they may be), and prevent avoidable return visits to the Emergency Department and/or re-admissions to the greatest extent possible.
- **Monitoring and evaluation (individual):** There is ongoing monitoring and evaluation of individual discharge and transition plans, with the lessons learned from each transition codified and shared to inform future efforts.
- **Shared accountability:** There must be shared accountability for patient outcomes and satisfaction across services, sectors and systems and over time. Service providers and the system believe in public accountability and transparency and work individually and

- **Monitoring and evaluation (system):** There must be ongoing monitoring and evaluation of the implementation of this framework and the impact it has on its defined outcome measures. Resources are dedicated to support both the framework's implementation and its evaluation over time.

4.2 Framework

Having assessed the current state, identified the key barriers to transition and determined the underlying issues to be addressed, the Advisory Committee developed a framework for the ongoing care and management of individuals with severe behavioural issues (including dual diagnosis) in the TC LHIN. The framework is comprised of four key components:

- **Continuum of care:** People designated ALC or who are at risk of being designated ALC need access to a comprehensive continuum of integrated services to meet their needs over time. This continuum should evolve over time based on the evaluation results of pilots and projects that are launched to continuously improve the system.
- **Pathways and transition processes:** No matter where people are along their care and recovery journey, there should be a clear pathway and high quality discharge and transition planning process in place to support them to get to their next most appropriate level of care. The Advisory Committee focused on the development of pathways to address the following situations:
 - The person is in hospital and at risk of being designated ALC
 - The person is in the community and at risk of admission to hospital
- **Components needed to make it all work:** People with severe behavioural issues, including dual diagnosis, rarely have linear, easily predictable care and recovery journeys. It is expected that people will make steps forward and then have setbacks from which they must recover over time. It is also expected that people will need to move into and out of various care settings of various service intensities over time, and this movement must be allowed for and accommodated without penalizing the individual for changes in his/her condition. Although the personal recovery and potential maximization process is rarely

linear, there are some components that if in place, will help smooth and keep people on their individual recovery and potential maximization paths. These components include:

- Inter-sectoral service coordination and integration
- Education and capacity-building
- Formal, consistent policies and processes
- System management and evaluation
- Advocacy for ongoing capacity enhancement
- Tools and templates

These components are represented within the framework as trees, both stable and enduring, but also able to bend and flex in response to changing conditions and needs.

- **Outcomes:** The Advisory Committee believes that with implementation of the above framework, people with severe behavioural issues and needs, including dual diagnosis, will be better able to proceed along their recovery and potential maximization journeys. Enabling this will result in four key individual- and system-level outcomes to be achieved:
 - Reduction in ALC days
 - Reduction in visits to the Emergency Department within 30 days of a prior hospital admission
 - Reduction in readmissions within 30 days of a prior hospitalization
 - Reduction in readmissions within 6 months and 1 year of a prior hospitalization (trial indicator)
 - Improved, patient and family/caregiver satisfaction with the healthcare system

The Advisory Committee's recommended framework is shown on the following three pages. The first diagram (Figure 1) represents the entire framework, and the following two pages (Figure 2) provide more detail on the specific areas of focus within each of the recommended six components.

Figure 1 – Framework

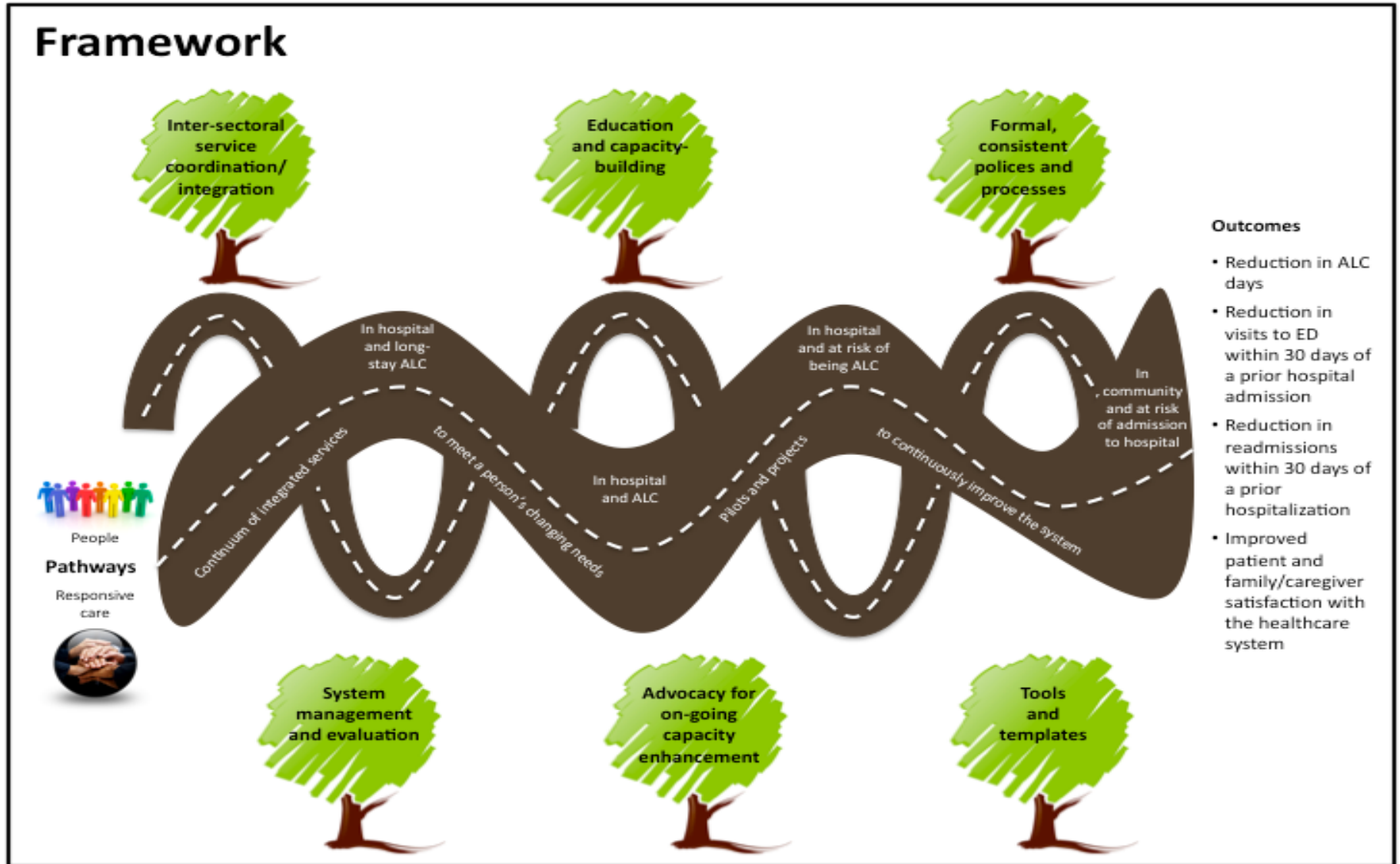


Figure 2 – Detail on Components Needed to Make It All Work

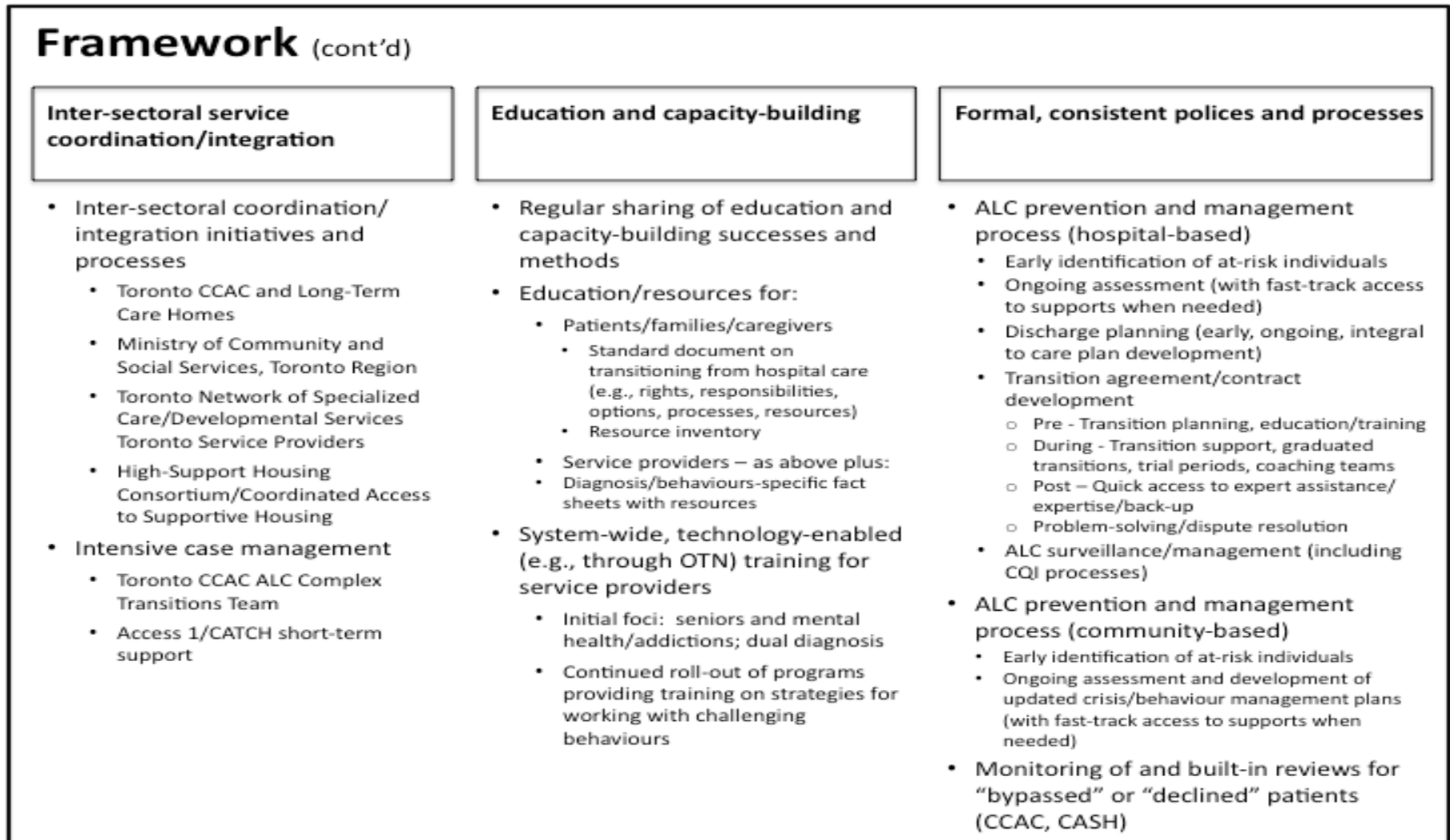
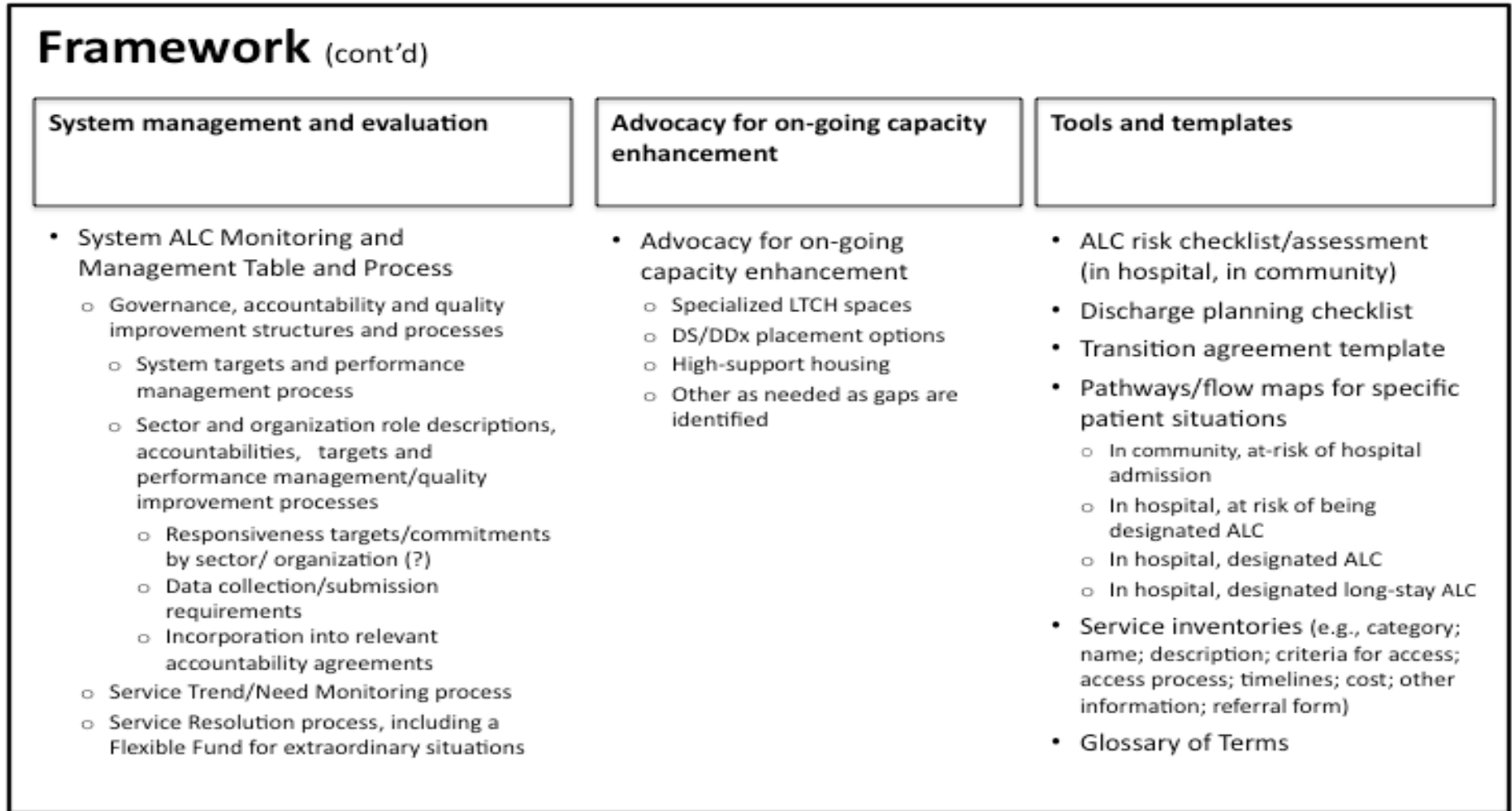


Figure 2 – Detail on Components Needed to Make It All Work (cont'd)



4.21 Continuum of Care

People with severe behavioural issues including dual diagnosis who are designated ALC, or who are at risk of being designated ALC, require access to a comprehensive continuum of integrated services to meet their changing needs over time. This continuum needs to offer people a range of service options that evolve both to meet people's changing needs and in response to new knowledge about what interventions and services really work to support people to maximize their recovery and potential. The continuum also needs to evolve based on the evaluation results of pilots and projects that are launched by service providers in their efforts to continuously improve the system.

The needed continuum of care is extensive and complex as it is actually a *combination* of four often separate care continuums: the mental health, addictions, dual diagnosis¹³, and seniors services care continuums. The Advisory Committee identified a total of 32 service categories to be included in the care continuum for people with severe behavioural management issues including dual diagnosis.¹⁴

Figure 3 shows the needed continuum of care for people with severe behavioural management issues including dual diagnosis. The chart also indicates for each service category, the *primary* target population(s) for that service category (√) and the populations(s) which service providers in that category should be able to serve *capably/competently* (♦).¹⁵ Existing services need to play a primary role in the ongoing care and support of people with severe behavioural issues including dual diagnosis. Many programs will need to be supported to change and adapt to better meet the needs of this population.

The service categories shaded in blue (■) are those which, after reviewing the data and information gleaned from its current state assessment, the Advisory Committee identified as being in *particular* need of attention in relation to the recommended framework's components – inter-sectoral service coordination and integration; education and capacity-building; formal,

¹³ Itself a continuum of service options that draws and integrates services provided by the developmental services and mental health sectors.

¹⁴ The Advisory Committee developed the continuums through review of *Making It Happen, The Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis*, Connex Ontario's Drug and Alcohol Registry of Treatment database, and the Community Seniors' Mental Health and Addiction Community Services Project and Community Navigation Access Project websites.

¹⁵ In this context, the term "capably/competently" means that a service provider is able to serve the majority of individuals in this population group (i.e., the group that have low-medium complexity and support needs). It should be noted that today, programs and agencies will have varying levels of capability and capacity in many of these areas, further emphasizing the need for a sustained education and capacity-building effort and capacity enhancement for selected specialized services.

consistent policies and processes; system management and evaluation; advocacy for ongoing capacity enhancement; and tools and templates. These services categories include:

- Intensive case management – which plays a key role in the: early identification of those at risk for becoming ALC; development and implementation of high quality discharge and transition plans; management of patients' transitions to their next level of care; and provision of ongoing support.
- Psychogeriatric outreach services – which play a key role in the: early identification of those at risk for becoming ALC (both in Long-Term Care, home and other community settings); development and implementation of high quality discharge and transition plans; provision of specialized outreach, education and capacity-building; provision of ongoing support; and provision of specialized back-up support when needed by receiving service settings.
- Schedule 1 inpatient services – which plays a key role in the: early identification of those at risk for becoming ALC; development and implementation of high quality discharge and transition plans; and provision of back-up support when needed by receiving service settings.
- Supportive housing (mental health) – which plays a key role in the: early identification of those at risk for becoming ALC (in supportive housing settings); development and implementation of high quality discharge and transition plans (for tenants in hospital); and provision of ongoing support.
- Residential supports (dual diagnosis) – which play a key role in the: early identification of those at risk for becoming ALC (in residential support settings); development and implementation of high quality discharge and transition plans (for residents); and provision of ongoing support
- Residential settings (seniors) – which play a key role in the: early identification of those at risk for becoming ALC (in residential settings) ; development and implementation of high quality discharge and transition plans (for seniors in hospital); and provision of ongoing support
- Specialized inpatient services – which play a key role in the: early identification of those at risk for becoming ALC (for patients in specialized inpatient service settings); development and implementation of high quality discharge and transition plans; provision of specialized

outreach, education and capacity-building; and provision of specialized back-up support when needed by receiving service settings.

Appendix I provides a description of each of the service categories and sub-categories.

4.22 Pathways and Transition Processes

The Mental Health and Addictions Alternate Level of Care Advisory Committee was asked to prepare a “*framework/model that organizes and manages the continuum of services for each population group.*” Because the population groups overlap and need access both to general and population-specific (i.e., specialized) services, the Advisory Committee chose to develop an overall framework for the ongoing care and management of individuals with severe behavioural management issues, including dual diagnosis (outlined in Section 4.2 of this report). The needed continuum of services is outlined in Section 4.21.

Pathways

The Advisory Committee was also asked to develop “*a hospital-based strategy that will identify and manage at risk individuals to prevent them from becoming ALC and ensure timely transitions to the most appropriate destinations.*” To provide a mechanism through which to organize and manage the continuum of services and supports, facilitate the early identification of individuals at risk for becoming ALC, and support timely transitions to the most appropriate next level of care, the Committee developed a set of clear pathways (or flow maps) through which people will move.

Pathways were developed for two scenarios: the person with severe behavioural issues including dual diagnosis is:

- i. In hospital and is at risk of being designated ALC; or
- ii. Living in the community¹⁶ and at risk of admission to hospital

¹⁶ For the purpose of these pathways, the term community is defined as a private home, group/boarded home, supportive housing, developmental services sector residential settings, long-term care home, shelter or street.

Figure 3 – Continuum of Care

No.	Service category	Population			
		Mental health	Addictions	Dual Diagnosis	Seniors
1.	Information and referral	√	√	√	√
2.	Crisis services				
	a. Crisis telephone services	√	√	√	√
	b. Mobile crisis services	√	√	√	√
	c. Emergency Department services	√	√	√	√
	d. Short-term residential services (i.e., “safe beds”)	√	√	√	√
e. Abuse services	√	♦	√	♦	
		√	√	√	√
3.	Primary care (including house calls by MDs for seniors with limited mobility)	√	√	√	√
4.	Initial assessment and treatment planning (addictions)	♦	√	♦	♦
5.	Counselling and treatment services (mental health)	√	♦	♦	♦
6.	Community treatment (addictions)	♦	√	♦	♦
7.	Intensive case management				
	a. Mental health	√	♦	♦	♦
	b. Addictions	♦	√	♦	♦
	c. Dual diagnosis	n/a	♦	√	♦
d. Seniors with complex needs	♦	♦	♦	√	
8.	Assertive community treatment	√	♦	♦	♦
9.	Early intervention in psychosis services	√	♦	♦	n/a
10.	Diversion and court support services	√	√	♦	♦
11.	Day hospital/treatment services (mental health)	√	♦	♦	♦
12.	Community withdrawal management (addictions)	♦	√	♦	♦

SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis

No.	Service category	Population			
		Mental health	Addictions	Dual diagnosis	Seniors
13.	Community day/evening treatment (addictions)	♦	√	♦	♦
14.	Community medical/psychiatric treatment (concurrent disorders)	√	√	♦	♦
15.	Schedule 1 outpatient services (mental health)	√	♦	♦	♦
16.	Psychogeriatric outreach services				
	a. Geriatric mental health outreach teams (GMHOT) to LTCHs	√	♦	♦	√
	b. Community psychogeriatric outreach teams (CPOT)	√	♦	♦	√
	c. Psychogeriatric resource consultants (PRC)	√	♦	♦	√
17.	Addictions community outreach services				
	a. Adult	♦	√	♦	♦
	b. Seniors	♦	√	♦	√
18.	Residential withdrawal management				
	a. Level I	♦	√	♦	♦
	b. Level II				
	c. Level III				
19.	Residential treatment (addictions)	♦	√	♦	♦
20.	Residential/psychiatric treatment (concurrent disorders)	√	√	♦	♦
21.	Schedule 1 inpatient services (mental health)	√	♦	♦	♦
22.	Psychosocial rehabilitation and community support services				
	a. Educational/vocational services (including alternative businesses)	√	♦	♦	♦
	b. Social/recreational services	√	♦	♦	♦
	c. Clubhouses	√	♦	♦	♦
	d. Peer support and consumer/survivor initiatives	√	√	√	√
23.	Specialized community supports (dual diagnosis; funded by MCSS)				
	a. Behavioural assessment and counselling services	n/a	♦	√	♦
	b. Speech and language therapy	n/a	n/a	√	♦

SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis

	c. Clinical support services	n/a	♦	√	♦
	d. Community outreach services (for caregivers)	n/a	♦	√	♦
	e. Urgent support services	n/a	♦	√	♦
No.	Service category	Population			
		Mental health	Addictions	Dual diagnosis	Seniors
24.	Community support services (seniors) a. Intervention and assistance services / non-intensive case management b. Medication management (e.g., daily phone calls to remind about medications) c. Support and counseling d. Adult day programs e. Recreational programs f. Meals on Wheels/ congregate dining g. Friendly visiting h. Transportation i. Volunteer services j. Caregiver support services k. Respite services l. Peer support services m. Home support services	♦	♦	♦	√
25.	Family support services	√	√	♦	♦
	a. Counselling and support services (individual, group) b. Peer support services	√	√	♦	♦
26.	Residential supportive treatment (addictions)				
	a. Level I b. Level II	♦	√	♦	♦
27.	Supportive housing (mental health)	√	♦	♦	♦
	a. Low-support	√	♦	♦	♦
	b. Medium-support c. High-support (transitional and long-term)	√	♦	♦	♦

SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis

28.	Residential supports (dual diagnosis) a. Supported independent living b. Group home living c. Family home arrangements d. Individual residential model settings e. Respite services and supports (through Special Services at Home)	n/a	♦	√	♦
No.	Service category	Population			
		Mental health	Addictions	Dual diagnosis	Seniors
29.	Residential settings (seniors) a. Retirement Homes b. Seniors supportive apartments c. Long-Term Care Homes (LTCHs) i. Behavioural support staff (PIECES) ii. Special care/behavioural units	n/a	n/a	n/a	√
		♦	♦	♦	√
		♦	♦	♦	√
30.	Specialized inpatient services a. Mental health b. Concurrent disorders c. Dual diagnosis d. Psychogeriatric	√	♦	♦	♦
		√	√	♦	♦
		n/a	♦	√	♦
		n/a	♦	♦	√
31.	Forensic services	√	√	√	√
32.	Palliative and end-of-life care	♦	♦	♦	√
29.	Residential settings (seniors)				
	a. Retirement Homes				
	b. Seniors supportive apartments				
	c. Long-Term Care Homes (LTCHs) i. Behavioural support staff (PIECES) ii. Special care/behavioural units				

SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis

The pathways are intended to cover the majority of settings and circumstances for the target population. It is recognized that some people may not be covered by these pathways, however as these sub-groups are discovered, the existing pathways can be modified to address their needs and/or new pathways be developed. The pathways are based on the assumption that the person is already in the most appropriate setting, and as such, provide a process through which safeguards are developed to prevent people from being designated ALC.

Figure 4 shows the pathway for the person with severe behavioural issues including dual diagnosis who is in hospital and is at risk of or is currently designated ALC. Figure 5 shows the pathway for the person with severe behavioural issues including dual diagnosis who is living in the community and is at risk of admission to hospital.

The Advisory Committee is currently completing the development of some tools and templates which should be used at key points in the pathway as shown. These tools include:

- ALC Risk Triggers Checklists (both general and behavioural-issues specific). Appendix J provides a draft of these checklists.
- A Discharge and Transition Planning Checklist, which is based on the discharge planning checklist developed and recommended by the Discharge Planning Steering Group, but tailored to even better meet the needs of people in the target population under consideration in this report. More detail on this checklist will be provided in the next section of this report.
- A Transition Agreement Template, to be used when developing the person's discharge and transition plan. The Transition Agreement, which is to be collaboratively developed by the patient, his/her family (or substitute decision-makers), sending hospital, receiving destination setting, and all related service providers, will specify the commitments and conditions of the person's discharge and transition plan as well as a crisis/behavioural management plan. It will also specify how the receiving destination can access back-up and/or enhanced support when needed.
- A Crisis/Behavioural Management Plan Template, to be developed collaboratively and used by the patient, family, and hospital and community service providers when someone is identified as being at risk for admission to hospital. The purpose of

developing and updating the crisis/behavioural management plan is to prevent the person's admission to hospital and stabilizing them in the community.

Transition processes

Fundamental to enabling people to move smoothly and successfully through the "person in hospital" pathway is implementation of a high-quality discharge and transition planning process. The Advisory Committee identified the 5 key components that comprise such a process. These include:

- Early identification of individuals at risk for being ALC
- Ongoing assessment (with fast-track access to supports when needed)
- Discharge planning (which takes place early in a person's hospital stay, is ongoing, and viewed as integral to care plan development)
- Transition agreement/contract development
- ALC surveillance/management (including continuous quality improvement processes)

The Advisory Committee then reviewed the ***draft*** discharge planning framework and checklists developed by the TC LHIN Discharge Planning Steering Group. The checklist developed for unscheduled admissions is the most relevant one for people with severe behavioural management issues. This is because scheduled admissions are infrequent for this population given the consistently high demand for mental health and addiction, dual diagnosis and psychogeriatric inpatient beds across the system (and in particular, for acute secure beds)

The Advisory Committee supports use of the Discharge Planning Steering Group's draft discharge planning framework and checklist for unscheduled (and scheduled, when they do occur) admissions, subject to some tailoring of the framework and checklists to increase their match with the Advisory Committee's key process components and their applicability to the Committee's target population. As the Advisory Committee received the discharge planning framework and checklists approximately one week before this report was due, it was unable to finalize its recommendations regarding the specific additions and/or changes to be made. However, the Committee did identify some key elements to be reviewed and tailored for the specific needs of people with severe behavioural issues which include:

Figure 4 – Person with severe behavioural issues including dual diagnosis is in hospital and is at risk of being designated ALC

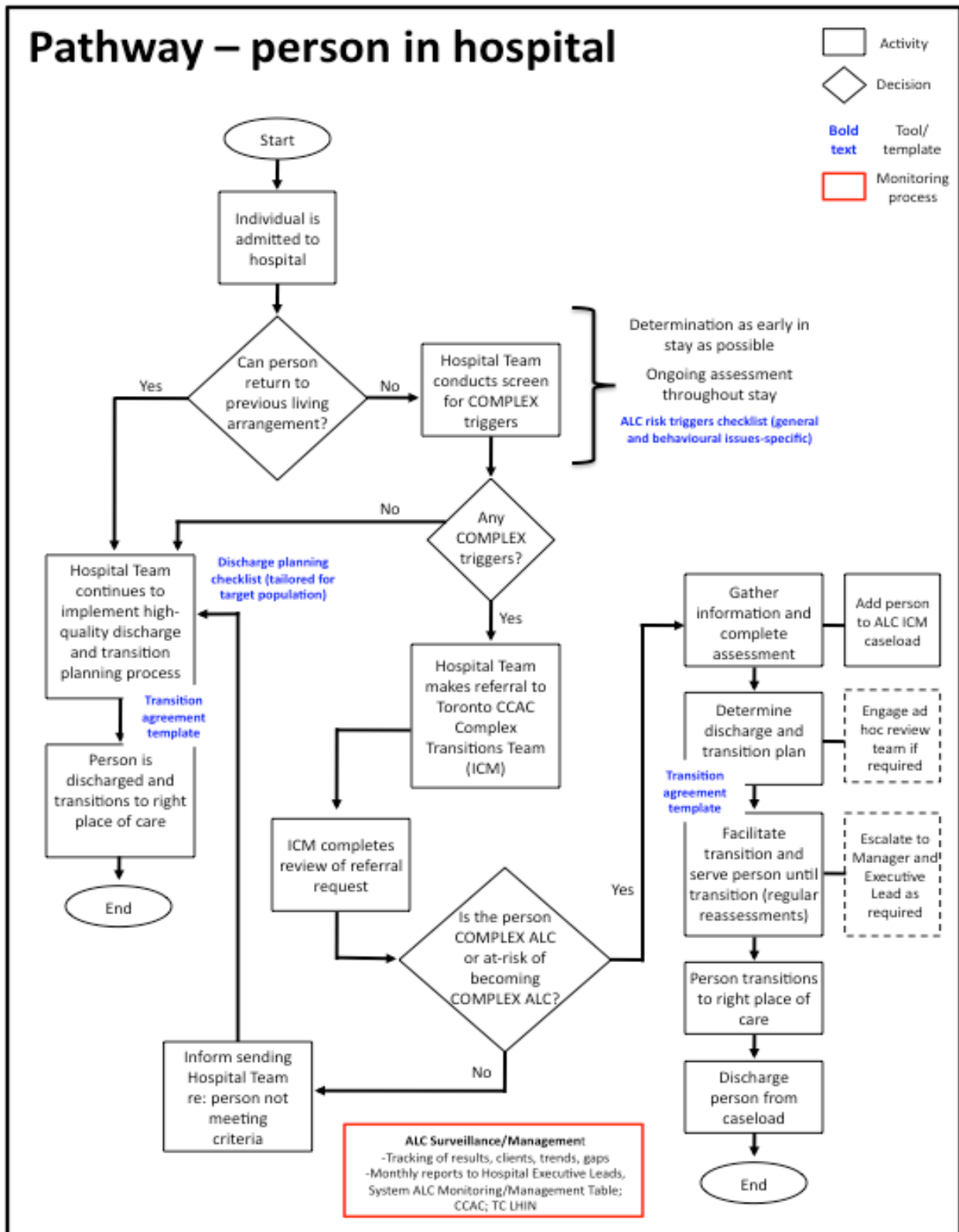
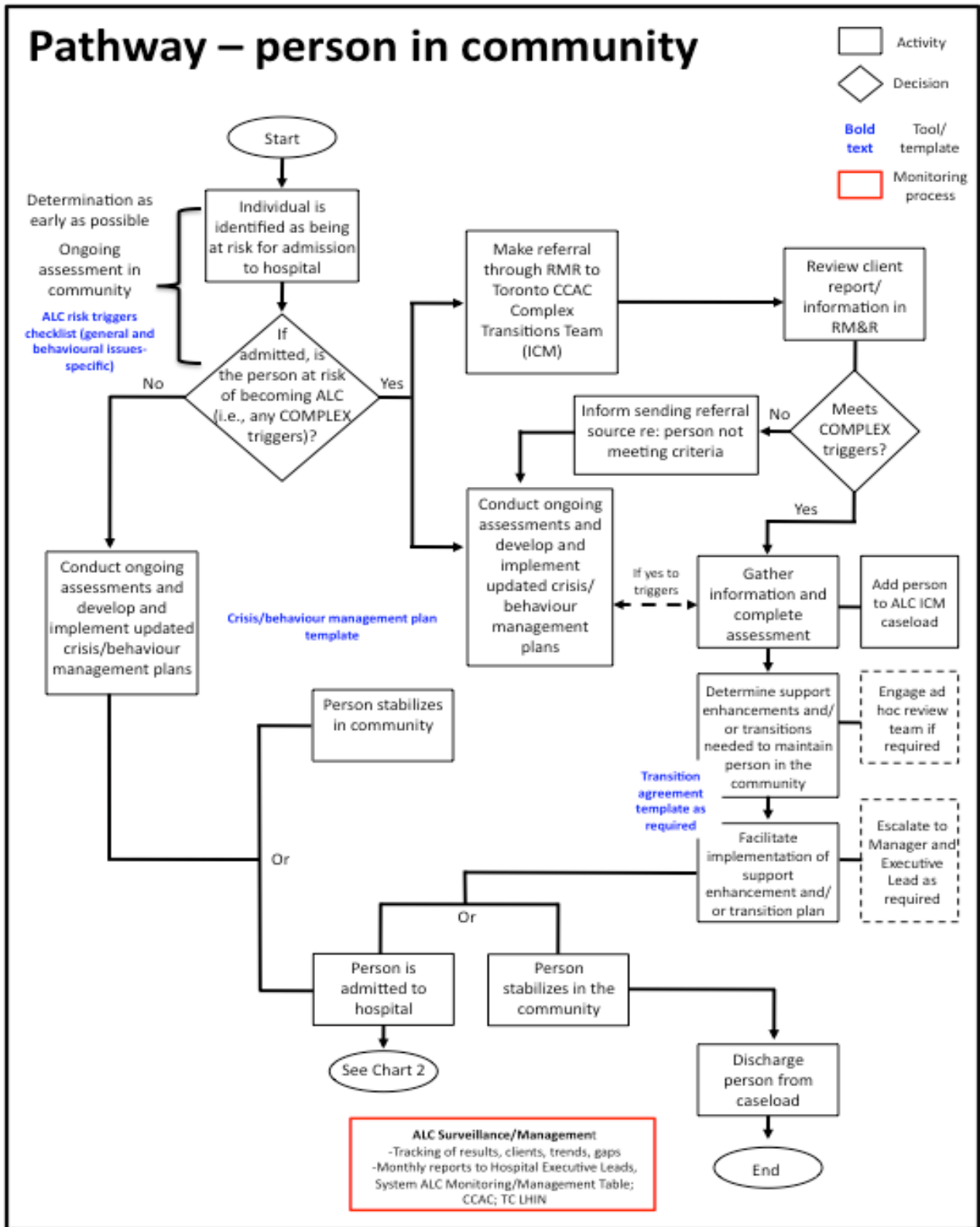


Figure 5 – Person with severe behavioural issues including dual diagnosis is living in the community and is at risk of admission to hospital



SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis

- Development and sharing (with consent) of patient care plans across hospital sites for frequent users of Emergency Department and inpatient services
- Use of the ALC Risk Triggers Checklist (once finalized) in the Emergency Department and on the day of admission and referral to the Toronto Central CCAC's Complex Care Transition Team as appropriate
- Early engagement of additional key services and their access points (i.e., beyond the currently identified Toronto Central CCAC and Rehab/CCC), such as the CATCH program, T-CAT, Access 1 (Intensive Case Management and Assertive Community Treatment Teams), Coordinated Access to Supportive Housing (CASH), Community Navigation and Access Program (CNAP), and Developmental Services Toronto (DSTO) to name a few.
- Development and documentation of the person's transition agreement/contract as soon as possible after admission and before discharge, using a standardized template that specifies, as appropriate:
 - Pre-transition planning, education and training requirements (including cross-location staff shadowing, meetings with the patient and his/her family and/or substitute decision-makers, tailoring of the accommodation setting)
 - During-transition supports, which could include the use of graduated transitions, trial periods, and coaching teams to better support the person and receiving destination acclimate
 - After-transition access to quick-response expert assistance and back-up (e.g., what can be accessed, when, and how)
 - Agreed-upon processes be used to address problems and resolve disputes
- Inclusion of hospital and receiving destination location satisfaction surveys following discharge

The Advisory Committee also supports the Discharge Planning Steering Group's recommendation that hospitals undertake a current state assessment of organizational discharge planning practices relative to the proposed framework and checklists (revised for its target population as described above), identifying opportunities for improvement and priorities for change in the coming fiscal year.

Fundamental to enabling people to move smoothly and successfully through the "person in

community” pathway is implementation in the community of two key ALC prevention and management components. The two components are:

- Early identification of at risk individuals; and
- Ongoing assessment and development of updated crisis/behaviour management plans (with fast-track access to supports when needed)

Finally, monitoring of and built-in reviews for “bypassed” or “declined” patients should be built into the Toronto Central CCAC Long-Term Care and Coordinated Access to Supportive Housing access processes.

These components will be discussed in more detail in Section 4.33 of this report.

RECOMMENDATION 1:

Adopt and support implementation of the recommended framework (i.e., continuum, pathways and transition processes) for the ongoing care and management of individuals with severe behavioural issues including dual diagnosis in the Toronto Central LHIN as described in Section 4.2 of this report.

Lead: Toronto Central LHIN

Timing: Year 1, as soon as possible following review of this report

4.3 Components Needed To Make It All Work

While people with severe behavioural issues and needs, including dual diagnosis, rarely have linear, easily predictable care and recovery journeys, the transitions they make along their journeys can be smoother, more timely and better supported. Listed below are the Advisory Committee’s recommendations regarding the six framework components that if put in place, will help smooth and keep people on their individual recovery and potential maximization paths.

4.31 Inter-sectoral service coordination and integration

Severe, complex and challenging behaviours typically result from complex conditions that typically require a multi-faceted service response from the health, social services and related sectors. Effective cross-sector collaboration, service coordination and integration at the individual-, program-, organization- and system-level is essential to supporting people being supported with the appropriate services in the appropriate settings.

The Advisory Committee has developed recommendations to improve inter-sectoral service coordination and integration with the following sectors and services:

SMOOTHING THE PATH: Addressing Alternate Level of Care Issues for People with Severe Behaviour Issues including Dual Diagnosis

- **Long-Term Care** – Many LTCHs do not have the skill, resources or capacity to support patients with severe behavioural issues safely. Conventional approaches to managing behaviours are often ineffective for patients with a developmental disability. The level of knowledge and capacity to support these patients in LTCHs varies by LTCH and is suboptimal overall. Implementation of the following recommendation will increase Long-Term Care Homes' capacity to better accommodate people with severe behavioural issues including dual diagnosis.
- **Developmental Services** – People with a developmental disability and mental health needs (dual diagnosis) require different types and intensities of service response from both the mental health and developmental services systems. Health, mental health and developmental services each have a role in the provision of services and supports to people with a dual diagnosis. Collaboration is needed among funders, organizations, programs and staff team levels.

Studies indicate that as many as one in 8 people in psychiatric hospitals have autism or a developmental delay as well as some form of mental illness. Although their needs are very complex, many will thrive in a 24-hour residential community-based environment that incorporates a strong clinical and rehabilitation component. This level of care is required because the management of behaviours such as extreme aggression, elopement and self-harm is not easily done in a more independent community-based setting. Currently there are approximately 12 such beds in the Toronto Network of Specialized Care that provide *transitional* housing with an average 2-4 year length of stay. Implementation of the following recommendation will enable the Developmental Services sector to increase its capacity to meet the needs of people with a dual diagnosis and severe behavioural challenges. As important as the actual capacity enhancement, is the development and implementation of a collaborative working and joint funding approach between the Toronto Central LHIN and MCSS Toronto Region.

- **Supportive Housing** – Supportive housing – particularly high-support supportive housing – is a critical component in the continuum of services for people with severe behavioural issues including dual diagnosis. This is particularly true for younger and middle-aged people, many of whom would prefer not to live in a Long-Term Care Home at this stage of their lives. Unfortunately, high-support housing comprises only 14% of the total supportive housing capacity in Toronto; of this percentage, approximately 45% is dedicated to seniors.

Currently, there are approximately 410 people on the waitlist for high-support housing. Approximately 50 high-support spaces become available in a given year, which means that even if the wait list grows no further,¹⁷ it will take 8 years to clear the waitlist for high-support housing. Implementation of the following recommendation may enable the high-support supportive housing sector to increase its capacity to accommodate more people with severe behavioural issues including dual diagnosis. It must be noted that the impact of this recommendation, without enhancement of high-support housing stock, will be limited, given the significant demand for such housing.

- **Intensive Case Management** – Preventing or intervening early in a patient’s hospital stay and ensuring that the right place of care is selected through effective discharge and transition planning, will contribute to addressing the system’s current ALC-related issues. As important is ensuring that there are designated staff accountable and responsible for transitioning the patient to their next level of care. These staff must be knowledgeable about system options, programs and partners and must be able to help the patient navigate effectively to the right place of care. Implementation of the following recommendation will enable the system to continue to increase its capacity to transition complex patients and to help ensure that it does not get “blocked” while patients remain on waitlists for community mental health intensive case management.

RECOMMENDATION 2:

Develop five inter-sectoral partnerships that increase the system’s capacity to better accommodate and meet the needs of people with severe behavioural issues including dual diagnosis.

- Establish a specialized behavioural needs unit in the Toronto Central LHIN¹⁸.

Lead: Centre for Addiction and Mental Health (CAMH), in partnership with a Long-Term Care Home located in the Toronto Central LHIN and the Toronto Central CCAC

Timing: Year 1, within 6 months, as a demonstration project of the province’s Behavioural Support Strategy.¹⁹

¹⁷ This is an unreasonable assumption given the sustained growth of the waitlist over the past couple of years).

¹⁸ A recommendation to support the creation of additional behavioural units in the Long-Term Care sector was also made by the participants in the Multi-Stakeholder Seniors Think Tank held on April 14, 2011.

¹⁹ The Advisory Committee recommends strongly that this recommendation be implemented as a demonstration project of the province’s Behavioural Support Strategy. The Advisory Committee should remain involved in an

- o Enhance the capacity of an existing Geriatric Mental Health Outreach Team (GMOT) to increase the amount of specialized behavioural support provided to Long-Term Care Homes and expand the age mandate of GMOTs to include people in their 40s-50s with similar need profiles as their current target population.

Lead: Centre for Addiction and Mental Health (CAMH), in partnership with a GMOT located in the Toronto Central LHIN

Timing: Year 1, within 6 months, linked to the initiative outlined above, again as a demonstration project of the province's Behavioural Support Strategy.¹⁹

- o Collaborate with the Ministry of Community and Social Services (MCSS), Toronto Region to enhance the developmental services system's capacity to support 4 individuals with dual diagnosis in high-support settings.²⁰

Lead: Toronto Central LHIN and MCSS Toronto Region, in collaboration with the Toronto Network of Specialized Care and the Developmental Services Toronto Service Providers Committee

oversight role through the project's implementation so as to not create additional silos within the system through the launch of independent, unlinked initiatives.

²⁰ This initiative would involve the Toronto Central LHIN and MCSS Toronto Region collaborating to co-fund high-support services for 4 identified individuals. A number of support models could be explored. One example could be the joint funding of a *long-term*, high-support 24-hour residential setting with integrated clinical services for people with a dual diagnosis who have very complex mental health and/or behavioural needs – individuals who without this setting and highly flexible, individualized care plans, would otherwise remain in hospital, become institutionalized and experience reduced functioning and poorer quality of life. Experience with the Toronto system indicates that clinical supports embedded in a housing program are more effective for this population than those provided by a separate support service organization. Based on this experience, the following elements would be proposed for this initiative:

- Slow and carefully planned transitions to get the person's intensive support team and environment in place, and ensure that they "gel" in support of the person
- Weekly clinical meetings to review and troubleshoot issues
- Individual bedrooms; more than 1 bathroom
- Common "safe area" indoors where people can be watched by staff, with staff and other residents out of harm's way if necessary (i.e., "reverse confinement")
- Safe outdoor space (i.e., a fenced-in yard)
- Additional safety measures as determined by client need, for example:
 - o Staff equipped with two-way radios/cell phones; alarms on locked doors; video surveillance, on-call emergency systems
 - o Padding in some rooms to keep individuals prone to self-injury safe
- Capacity to transport residents safely to appointments and community leisure activities
- Higher staff ratios than usual (including "awake overnight" staff) that can be increased and reduced (i.e., flexed) when necessary

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Timing: Year 1, within 6 months

- Determine whether there are (and if yes, develop a process to capitalize on) opportunities to increase flow through the sector's high-support housing settings through the creation of "step-down" opportunities for people currently living in high-support housing who no longer need that level of support.²¹

Lead: High-Support Housing Consortium (which includes representation from high-support housing settings, the Toronto Central LHIN and Toronto Central LHIN hospitals)

Timing: Year 1, within 12 months

- Continue implementation of the CCAC Complex Transitions Team Intensive Case Management (ICM) model across all TC LHIN hospitals with particular emphasis on:
 - Ongoing education of and marketing to hospital and community stakeholders as to the Toronto CCAC ALC Complex Transitions Team and available alternate level of care options
 - Utilization of the Resource Matching and Referral (RM&R) system to support the referral process all ALC destinations including supportive housing, attendant care, transitional programs and geriatric assessment and treatment programs through the RM&R system
 - Development of a partnership and referral relationship with Toronto North Support Services that includes access to a dedicated Short-Term Support Case Manager (1.0 FTE) either at Access 1 or CATCH (depending on the specific characteristics of the population to be served) who would provide continued transition support as needed to ALC patients waiting for access to

²¹ It is not assumed that there are significant numbers of people living in high-support housing settings who do not need this level of support, particularly given the limited amount of high-support housing in Toronto. Nevertheless, the Advisory Committee felt that it was worthwhile for the supportive housing sector to engage in a discussion as to whether and how flow could be increased through these services, as other mental health services have done across the sector. This discussion would need to identify under what circumstances and how such transitions could be accomplished; determine what kinds of supports need to be in place to allow for step-down transitions to occur successfully (i.e., it is unlikely that people transitioning from high-support housing will not need some enhancement of supports in other settings, particularly given the ever-increasing aging-related medical and other needs faced by the population); determine incorporate systematic response strategies should a transitioned person's needs increase again over time; and determine and include a recommended strategy, process and implementation plan to facilitate identified transition opportunities over time.

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mental health ICM or Assertive Community Treatment Team services as part of their longer-term community support plans

Lead: Toronto Central CCAC, in partnership with Toronto Central LHIN hospitals and Toronto North Support Services

Timing: Year 1, within 12 months

These projects should be evaluated and based on their results, plans should be developed to replicate successes where indicated.

RECOMMENDATION 3:

Build on and refine three existing inter-sectoral processes to increase inter-sectoral alignment and capacity to better meet the needs of people with severe behavioural issues including dual diagnosis:

- Build on the Toronto Network of Specialized Care's current Service Resolution process to include more formal and standardized mechanisms to highlight and collaboratively address ALC-related and other issues with the Toronto Central LHIN on a regular basis.

Lead: Toronto Network of Specialized Care Service Resolution Committee in collaboration with the Toronto Central LHIN, MCSS Toronto Region and Developmental Services Toronto Service Providers Committee

Timing: Year 1, within 12 months

- Working within the framework of the *Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis*, engage in an inter-sectoral process to align, at a minimum, MCSS and Ministry of Health and Long-Term Care (MOHLTC) / Toronto Central LHIN principles, objectives, outcomes and action plans regarding:
 - The respective roles each has in the provision of clinical care and supports and long-term care and supports to people with a dual diagnosis
 - Development and implementation of integrated corporate and regional service planning and monitoring mechanisms
 - Development of a shared funding methodology, investment plan and accountability process to guide future planning and investment in the sector

Lead: Toronto Central LHIN; MOHLTC; MCSS Toronto Region

Timing: Year 2 and ongoing

- Determine whether and how people who are designated ALC in hospital could be prioritized for access to transitional or permanent supportive housing, when to do so would be more cost-effective from a system perspective.

Lead: Coordinated Access to Supportive Housing Network (CASH) and Toronto Central LHIN hospitals in collaboration with the Toronto Central LHIN

Timing: Year 1, within 12 months

4.32 Education and capacity-building

Many of the barriers experienced when attempting to transition someone with severe behavioural issues to their next level of care result from insufficient awareness, skills, confidence and/or willingness on the part of receiving care settings. Patients, families and caregivers can also lack information and knowledge about their rights, responsibilities, options and choices. These situations usually are a function of either lack of knowledge of available placement options and levels of care, fears of and/or concerns about the risks associated with unsuccessful transitions, insufficient skills, resources or capacity (real or perceived) to support selected patient populations, or plain old discrimination against the target population. All of these situations can be addressed through a concerted and sustained education and capacity-building strategy.

RECOMMENDATION 4:

Establish a time-limited cross-sectoral Task Group to gather, refine and facilitate widespread dissemination of standard information and resources²² as listed below:

- For patients, families and caregivers
 - A standard document that provides standardized information on transitioning from hospital care (e.g., rights, responsibilities, options, processes, resources)
 - A resource inventory that provides accurate information on all of the recommended service categories and constituent services for people with

²² A recommendation to build on and promote shared resource databases was also made by the participants in the Multi-Stakeholder Seniors Think Tank held on April 14, 2011.

severe behavioural issues including dual diagnosis, as outlined in Section 4.21 of this report²³

- Service providers
 - As above for patients, families, and caregivers
 - Diagnosis and behaviours-based fact sheets (that include relevant resources and contact information)

Lead: Toronto Central LHIN to designate lead; designated lead to establish and work with the cross-sectoral task group to leverage and enhance materials already under development or in use across the system.

Timing: Year 1, within 12 months

RECOMMENDATION 5:

Partner with the Ontario Telemedicine Network (OTN) to establish an ongoing series of capacity-building education and training seminars with particular emphasis on:

- Enhancing the community's capacity support seniors with mental health and/or addictions needs; and people with dual diagnosis²⁴
- Continued roll-out programs that provide training on strategies for working with challenging behaviours (e.g., Partners for the Prevention of Aggressive Behaviours program)

Lead: Designated lead as established through Recommendation 4 above.

Timing: Year 2 and ongoing

4.33 Formal, consistent policies and processes

Other barriers to timely and effective transitions can be explained by the lack of formal, consistent policies and processes. Advisory Committee members described the wide-ranging discharge and transition planning processes in place across hospitals in the Toronto Central LHIN. Various stakeholders described their frustration when trying to understand simply how

²³ The Toronto Central CCAC is already developing this service inventory; the task group should contribute to this work to ensure that it accurately captures all of the services outlined in the service continuum recommended earlier in this report.

²⁴ A recommendation to design education and cross-training programs for a range of stakeholders including families and caregivers, was also made by the participants in the Multi-Stakeholder Seniors Think Tank held on April 14, 2011. The Toronto Network of Specialized Care already has a partnership with the OTN; this partnership should be expanded and enhanced as part of this recommendation.

things were *supposed* to work, and no one being able to tell them, because no policies had ever been developed and documented regarding how relatively routine activities are to be handled. The most significant policy and process gap identified by the Advisory Committee was the lack of a consistent ALC prevention and management process (including skills training) across TC LHIN hospitals and with the community.

RECOMMENDATION 6:

Undertake a current state assessment of organizational ALC prevention and management processes relative to the recommended five-stage discharge and transition planning process and the Discharge Planning Steering Group's checklists (once tailored for our target population). Use this assessment to identify opportunities for improvement and to develop and implement plans to capture them.²⁵

Lead: Toronto Central LHIN hospitals

Timing: Year 1, within 12 months and ongoing

RECOMMENDATION 7:

Undertake a current state assessment of community organization ALC prevention and management relative to the two components proposed in this report. Use this assessment to identify opportunities for improvement and to develop and implement plans to capture them.²⁶

Lead: Toronto Central LHIN Long-Term Care Homes, Community Mental Health and Addiction Programs, and Developmental Services providers that serve people with a dual diagnosis.

²⁵ Implementation steps should include identification of a senior lead responsible to serve as the Executive Sponsor for the ALC prevention and management process improvement effort; and identification of priorities for change in the coming fiscal year resulting in minimum standards being met for: i) adoption of the ALC risk checklists (general and behavioural issues-specific) as screening tools to be used prior to or upon admission (e.g., in the ED) with people with severe behavioural issues including dual diagnosis; ii) establishment of the Expected Discharge Date (EDD) as early as possible and no later than the 3rd day of admission; iii) completion of the Transition Agreement in 85% of patient transitions and at least 1 day before discharge; iv) timely and complete medication reconciliation performed on admission and on discharge; and v) discharge summary (with minimum information set) completed for all patients to take with them on the day of discharge

²⁶ Implementation steps should include identification of a senior lead responsible to act as the Executive Sponsor for the identified ALC prevention and management improvement effort; and identification of priorities for change in the coming fiscal year resulting in minimum standards being met for: i) adoption of the ALC risk checklists (general and behavioural issues-specific) as early identification tools to be used on a regular basis with people living in the community with severe behavioural issues (including dual diagnosis) who are at risk for admission to hospital; ii) updated crisis/behaviour management plans being in place for 85% of clients identified as being at risk for admission to hospital; and iii) participation in the Transition Agreement development process 85% of the time for community program clients who are admitted to hospital while engaged with the community program.

Timing: Year 2 and ongoing

RECOMMENDATION 8:

Ensure the existence and widespread awareness of standard review and issue resolution processes for cases when people with severe behaviour issues including dual diagnosis are “bypassed” or “declined” by Long-Term Care Homes or supportive housing providers.

Lead: Toronto Central CCAC (in relation to LTCHs) and CASH (in relation to supportive housing)

Timing: Year 1, within 12 months and ongoing

4.34 System management and evaluation

Long-stay ALC patients who have severe behavioural issues including dual diagnosis have complex individual circumstances and needs for which there has not been a system response. In addition to internal hospital ALC monitoring processes, a cross-sectoral system management and evaluation process is needed to ensure ongoing monitoring and evaluation of the implementation of this framework and the impact it has on reducing ALC cases and days across the system. Only in this way will true shared accountability for patient outcomes and satisfaction emerge across services, sectors and systems over time.

RECOMMENDATION 9:

Establish a cross-sectoral System ALC Monitoring and Management Table and Process that is designed and implemented based on the principles of shared responsibility for system outcomes and continuous quality improvement at the program, organization, sector and system level. The system management process should include:

- Accountability and quality improvement structures and processes that:
 - Establish and monitor both outcome and process system targets and metrics in relation to people with severe behavioural issues including dual diagnosis;
 - Ensure clarity around sector and organization roles, accountabilities, targets and performance management and quality improvement processes;
 - Establish and ensure transparency regarding responsiveness targets and quality improvement commitments by sector and organization

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- Ensure clarity around data collection and submission requirements; and
- Are incorporated into relevant organization and sector accountability agreements
- A Service Trend and Needs Monitoring process that informs ongoing cross-sectoral service planning and investment
- A Service Resolution process for use in situations where all regular discharge and transition planning processes and resources have been exhausted and unsuccessful, with access to a Flexible Fund to address extraordinary situations

Lead: Toronto Central LHIN

Timing: Year 1, within 6 months and ongoing

The System ALC Monitoring and Management Table should be responsible for overseeing the implementation of the recommendations in this report. Reporting in to the Table should be two *time-limited* task groups which include:

- A Task Group²⁷ charged with reviewing and refining the Discharge Planning Steering Group's recommended Discharge Planning Process/Checklist for Unscheduled Admissions to incorporate the additional discharge planning components and tasks outlined in this report (timeframe – within 2 months); and
- The Task Group charged with gathering, refining and facilitating widespread dissemination of standard information and resources on ALC, discharge and transition planning facts, processes and resources to patients, families, caregivers and service providers across the system (Recommendation 4; timeframe – within 12 months)

The System ALC Monitoring and Management Table should also support its sector member representatives to establish and facilitate knowledge-sharing and relationship-building processes and events. Examples include:

²⁷ Comprised of selected Discharge Planning Steering Group and Mental Health and Addictions Alternate Level of Care Advisory Committee (which cross-sectoral membership from the Developmental Services sector)

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- Regular local and city-wide Long-Term Care Home and Hospital meetings to share information, build relationships and conduct joint problem-solving on local and system-level issues.²⁸

Lead: Toronto Central CCAC

Timing: Year 1, as soon as possible following review of this report

- Semi-annual Supportive Housing and Hospital meetings to share information, build relationships and conduct joint problem-solving on system-level issues.

Lead: High-Support Housing Consortium in collaboration with CASH and Toronto Central LHIN hospitals

Timing: Year 1, within 12 months and ongoing

- An annual cross-sectoral event focused on sharing education and capacity-building successes (e.g., partnerships, education and training, resources, methods and approaches), challenges, and stakeholder feedback from across the system

Lead: Toronto Central LHIN

Timing: Year 1, within 12 months, annually thereafter

4.35 Advocacy for ongoing capacity enhancement

Given current levels of capacity and demand, it is estimated that it will take 5 years to clear the existing waiting list for high-support supportive housing. For people with a dual diagnosis, current figures suggest that it could take 18 years to clear the high-support residential setting waiting list.²⁹ The above figures do not even account for the increasing demand for specialized behavioural services within Long-Term Care Homes and the demands that an aging population will place on the system. It is clear that while implementation of the recommendations in this report will help to reduce ALC days and ensure more people are being supported at the right level of care, a *significant* gap will remain in the amount and range of specialized and high-support housing and residential service options available to people who need this level of support. The ALC problem will not be solved without concerted, sustained, cross-sectoral effort and investment in high-support long-term care, residential and

²⁸ For example, modify existing Long-Term Care Home meeting structures and processes to establish a quarterly schedule of local meetings held in months one and two, and a city-wide meeting in month three.

²⁹ There are currently 271 people waiting on the Toronto Network for Specialized Care's high-support residential waiting list. Approximately 15 vacancies come up per year. This number varies significantly from year to year and not all of the vacancies that come up have the capacity to meet the needs of someone with a complex dual diagnosis.

supportive housing options, as well as ongoing reviews and expansion of existing and development of new high-support service models or options.

RECOMMENDATION 10:

Collaborate with existing networks and system stakeholders to enhance and communicate the business case to key decision-makers, both systematically and opportunistically, for enhanced, sustained investment in high-support supportive housing options, transitional housing options and high-support 24-hour residential settings with integrated clinical services for people with severe behavioural issues including dual diagnosis.

Lead: ALC System Management Table (recommended above) in collaboration with sector groups and committees (e.g., Toronto Network of Specialized Care; Developmental Services Ontario Service Providers Committee; Coordinated Access to Supportive Housing (CASH); High-Support Housing Consortium; the to-be-established city-wide Long-Term Care Home and Hospital meeting table).

Timing: Year 1, within 12 months, and ongoing

4.36 Tools and templates

To support ongoing implementation of the recommendations contained in this report, the Advisory Committee is in the process of developing a number of tools and templates to be used across the system. A couple of the tools and templates need some additional cross-sectoral review and refinement, however once complete, these tools and templates should be disseminated across the system.

RECOMMENDATION 11:

Disseminate the following tools and templates for use by all relevant stakeholders in the implementation of this report's recommendations:

- ALC risk triggers checklists (general and behavioural issues-specific; Appendix J)
- Discharge planning checklist
- Transition agreement template
- Transition agreement development meeting agenda template
- Pathways/flow maps for specific patient situations

- In hospital, at risk of being designated ALC
- In community, at risk of hospital admission
- Resource inventory
- Glossary of Terms

Lead: Toronto Central LHIN

Timing: Year 1, within 12 months and ongoing

4.4 Outcomes To Be Achieved

Implementation of the recommended framework, together with enhanced, sustained investment in high-support housing and residential settings, will enable people with severe behavioural issues and needs, including dual diagnosis, to better advance on their recovery and potential maximization journeys. Their paths and transitions among levels of care will be timelier, smoother and will result in fewer days spent in inappropriate levels of care. Enabling all of the above will result in four key individual- and system-level outcomes to be achieved, which include:

- Reduction in ALC days
- Reduction in visits to the Emergency Department within 30 days of a prior hospital admission
- Reduction in readmissions within 30 days of a prior hospitalization
- Improved, patient and family/caregiver satisfaction with the healthcare system

Ensuring achievement of these outcomes requires monitoring of a number of outcome and process metrics by the recommended System ALC Management and Monitoring Table. These metrics include:

- Outcome metrics
 - Number of ALC days
 - 30-day Emergency Department return visit rate
 - 30-day readmission rate
 - 6 month and 1 year readmission rate (trial indicator)
 - Patient and family/caregiver satisfaction
 - Service provider confidence and satisfaction
- Process metrics

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- Adoption of the ALC risk triggers checklists as screening tools
- Establishment of the Expected Discharge Date (EDD) on the target date
- Timely completion of the Transition Plan Agreement
- Timely completion of medication reconciliation
- Timely discharge summary completion
- Updated crisis/behaviour management plans in place for target clients
- Community mental health program participation in the Transition Agreement process

5.0 IMPLEMENTATION

The Advisory Committee recommends that the Toronto Central LHIN establish the cross-sectoral System ALC Monitoring and Management Table to oversee implementation of The Framework and its component recommendations. This should be done immediately following the TC LHIN's review and approval of The Framework and the recommendations in this report.

The Advisory Committee developed draft implementation plans for five of its more significant near-term recommendations, which include:

- Create a Specialized Behavioural Unit in the Toronto Central LHIN
- Enhance an existing Geriatric Mental Health Outreach Team(s)
- Enhance the Developmental Services system's capacity to support 4-5 individuals with dual diagnosis in high-support settings
- Increase access to high-support housing for ALC patients
- Increase access to transitional intensive case management in the community for ALC patients

The plans outline key activities, timeframes (from project initiation) and responsibilities for each of the identified deliverables and set of anticipated outcomes.

The Advisory Committee also developed key messages to be included in the communications plan developed to support implementation of the Framework, highlighted capacity issues and other risks that might interfere with implementation, and identified resource requirements for the various pilots and other initiatives recommended in the report.

5.1 Implementation Plans

5.11 Create a Specialized Behavioural Unit in the Toronto Central LHIN

This implementation plan is informed by the experience of Cummer Lodge (CL), a Long-Term Care Home in northeast Toronto with a specialized behavioural unit (see "comments" for details).

Anticipated outcomes of this project include:

- More admissions to LTC of people with challenging behaviours
- Averted inpatient admissions from LTCHs to CAMH or acute care hospitals
- Increased satisfaction of LTC Home staff

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Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> Identify suitable and interested LTC Home 	Month 1	<ul style="list-style-type: none"> CAMH * TC LHIN 	<ul style="list-style-type: none"> LTCH must be large enough to accommodate a separate locked unit on the premises
<ul style="list-style-type: none"> Confirm clear criteria for admission and develop access plan 	Month 2	<ul style="list-style-type: none"> CAMH LTCH 	<ul style="list-style-type: none"> Admission criteria –unprovoked aggression, anti-social and sexually inappropriate behaviour Separate waiting list Accepts patients from across the province Accepts forensic patients
<ul style="list-style-type: none"> Confirm model of care 	Month 2	<ul style="list-style-type: none"> CAMH LTCH 	<ul style="list-style-type: none"> Transitional: to stabilize patients at their own pace and then transition elsewhere in the LTC system Since its opening in April 2010, 12 people have gone through the unit LOS: 4-8 months
<ul style="list-style-type: none"> Confirm number of beds 	Month 2	<ul style="list-style-type: none"> CAMH LTCH 	<ul style="list-style-type: none"> 8 beds
<ul style="list-style-type: none"> Confirm costs for any required renovations 	Month 2	<ul style="list-style-type: none"> LTCH 	<ul style="list-style-type: none"> Windows in doors not permitted due to safety concerns
<ul style="list-style-type: none"> Develop resident: staff ratios and staffing plan 	Month 2	<ul style="list-style-type: none"> CAMH LTCH 	<ul style="list-style-type: none"> Recruited from within and provided training Higher number of Personal Support Workers (PSWs) and RNs than for other units Access to physician with expertise in aging and mental health to address medication issues Additional position - Behavioural OT, Nurse Practitioner (to provide leadership, connectivity between services, support optimized scope of practice for unit RNs, education and training)
<ul style="list-style-type: none"> Confirm final numbers / costs 	Month 2	<ul style="list-style-type: none"> CAMH LTCH 	
<ul style="list-style-type: none"> Secure required approvals from TC LHIN 	End of Month 2	<ul style="list-style-type: none"> LTCH TC LHIN 	
<ul style="list-style-type: none"> Complete recruiting 	End of Month 3	<ul style="list-style-type: none"> LTCH 	
<ul style="list-style-type: none"> Train staff 	Month 4	<ul style="list-style-type: none"> CAMH LTCH 	
<ul style="list-style-type: none"> Receive clients 	Beginning of Month 5	<ul style="list-style-type: none"> LTCH 	<ul style="list-style-type: none"> Takes approximately 2 months from “green light” approvals to opening

* It is recommended that CAMH remain involved in the initial planning and operationalization of the specialized behavioural unit as part of its overall responsibilities for the ALC initiative for people with severe behavioural management issues including dual diagnosis. This initiative should also be implemented as a demonstration project of the province’s Behavioural Support Strategy. This is to prevent the creation of additional silos within the system through the launch of independent, unlinked initiatives. Once the unit is operational, ongoing oversight will lie with TC LHIN.

5.12 Enhance an existing Geriatric Mental Health Outreach Team(s)

This implementation plan is informed by preliminary discussions with two existing Geriatric Mental Health Outreach Teams in the Toronto Central LHIN (see “comments” for details).

Anticipated outcomes of this project include:

- Increased number of outpatient consultations and visits to Long-Term Care Homes
- More admissions to LTC of people with challenging behaviours
- Averted inpatient admissions from LTCHs to CAMH or acute care hospitals
- Increased satisfaction of LTC Home staff

Activity	Timing	Lead	Comments
• Confirm suitable and interested GMOT(s)	Month 1	• CAMH • TC LHIN	• Interest has already been expressed by UHN and CAMH’s GMOTs
• Consult with LTC Homes to confirm interest and needs	Month 2	• GMOT(s)	• Key issue to address: <ul style="list-style-type: none"> ○ Intensive focus in one or 2 locations OR ○ Broader reach but less-intensive focus
• Confirm scope of expansion and required resources	Month 2	• GMOT(s)	• Have secured preliminary estimates from UHN and CAMH <ul style="list-style-type: none"> ○ Funding for FTE enhancement (medical and non-medical) and travel costs ○ Must be refined (i.e., specific skill mix) based on more in-depth needs assessment
• Recruit staff	Month 2	• GMOT(s)	
• Begin operations	Month 3	• GMOT(s)	• Working with existing GMOT allows for quick start up

5.13 Enhance the Developmental Services system’s capacity to support 4 individuals with dual diagnosis in high-support settings

This implementation plan is based on “A Rationale for a High-Support 24-Hour Setting” developed by Susan Morris, Clinical Director, Dual Diagnosis Program, Centre for Addiction and Mental Health, and Chair of the Toronto Network for Specialized Care (Appendix K).

Anticipated outcomes of this project include:

- A model and approach to collaborative funding and support of services for people with dual diagnosis who have severe, complex behavioural management issues and needs
- An increased number of individuals with dual diagnosis being served in intensive support settings appropriate to their levels of need
- Reduction in the individuals’ aggressive and challenging behaviours (e.g., recent reviews of similar transitional support settings have shown a reduction in such behaviours among 80% of the residents discharged from a long-stay specialized dual diagnosis hospital program at six-month and one-year follow-ups)
- Further improvements in the individuals’ quality of life and satisfaction

Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> • Convene meeting of “Consortium” - TC LHIN, MCSS Toronto Region, Toronto Network of Specialized Care (TNSC), Developmental Services Toronto (DSTO) Service Providers Committee, and CAMH Dual Diagnosis Program 	Month 2	<ul style="list-style-type: none"> • TC LHIN, MCSS Toronto Region, with support from CAMH 	<ul style="list-style-type: none"> • To explore opportunities and challenges and develop plan for moving forward • To review and select from potential high-level models of care • TC LHIN and MCSS must confirm their interest in proceeding with this project before a meeting is convened to plan and implement it.
<ul style="list-style-type: none"> • Identify: individuals to be served through the project; potential providers with expertise and interest in developing the project; and location(s) 	Month 2	<ul style="list-style-type: none"> • Consortium 	<ul style="list-style-type: none"> • Some options have been identified – Mens Sana; Kerry’s Place, New Leaf, Community Living Toronto – but there may be others
<ul style="list-style-type: none"> • Request preliminary proposals from interested providers 	Month 3	<ul style="list-style-type: none"> • Consortium 	

Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> • Select provider based on preliminary proposals 	Month 3	<ul style="list-style-type: none"> • TC LHIN and MCSS Toronto Region 	<ul style="list-style-type: none"> • Discussion needed between the TC LHIN and MCSS Toronto Region to determine the role of the TNSC and the DSTO Service Providers Committee in the service provider selection process
<ul style="list-style-type: none"> • Develop detailed model of care, including full costing 	Month 5	<ul style="list-style-type: none"> • Selected provider, with support from Consortium 	
<ul style="list-style-type: none"> • Begin implementation (i.e., confirm location, renovations, staffing) 	Month 6	<ul style="list-style-type: none"> • Selected service provider 	

5.14 Increase access to high-support housing for ALC patients

This implementation plan is informed by preliminary discussions with some members of the High-Support Housing Consortium.

Anticipated outcomes of this project include:

- Determination of the potential to increase access to high-support housing for ALC patients through prioritization and flow-increasing strategies
- Increased access to high-support housing for ALC patients

Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> • Convene Work Group to explore potential of and options for: <ul style="list-style-type: none"> ○ Priority access to high-support housing for ALC patients ○ Increasing flow through high support housing 	Month 2	<ul style="list-style-type: none"> • TC LHIN in collaboration with the High-Support Housing Consortium (i.e., selected CASH and TC LHIN hospital representatives) 	
<ul style="list-style-type: none"> • Submit preliminary report to the TC LHIN 	Month 4	<ul style="list-style-type: none"> • High-Support Housing Consortium 	<ul style="list-style-type: none"> • Issues and options

Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> • Submit final report, including implementation plan and costing 	Month 6	<ul style="list-style-type: none"> • High-support Housing Consortium 	<ul style="list-style-type: none"> • Costing to include any costs to support transition of people currently living in high-support housing who would like and can transition to lower levels but who need some enhanced supports to be able to do so
<ul style="list-style-type: none"> • Implement recommendations 	Months 7-12	<ul style="list-style-type: none"> • High-Support Housing Consortium and specific high-support housing providers 	

5.15 Increase access to transitional intensive case management in the community for ALC patients

This implementation plan is informed by preliminary discussions with Access 1.

Anticipated outcomes of this project include:

- Provision of more seamless support for discharged ALC patients who need long-term ICM as part of their discharge and transition plan (which should reduce the number of people who return to hospital as a result of breaks in their service and subsequent deterioration of their conditions)
- Sustained flow through the Toronto Central CCAC Complex Transitions Team (i.e., the Team will not need to “hold onto” people until long-term intensive case management spaces become available), allowing them to support more people before, during and in the early stages post-discharge.

Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> • Further define the population to be served through this initiative 	Month 3	<ul style="list-style-type: none"> • Toronto Central CCAC • Toronto North Support Services 	<ul style="list-style-type: none"> • More specific population definition needed to determine whether the services should be accessed via Access 1 or CATCH

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Activity	Timing	Lead	Comments
<ul style="list-style-type: none"> • Formalize a partnership and access protocol between the Toronto Central CCAC and Toronto North Support Services 	Month 4	<ul style="list-style-type: none"> • Toronto Central CCAC • Toronto North Support Services 	<ul style="list-style-type: none"> • Service will provide short-term ICM following engagement with the Toronto Central CCAC Complex Transitions Team, both to: <ul style="list-style-type: none"> ○ Provide a bridge to long-term services for which there is a wait ○ Facilitate flow through the Toronto Central CCAC Complex Transitions Team
<ul style="list-style-type: none"> • Recruit a Short-Term Support Case Manager to support ALC patients following their discharge from hospital 	Month 4	<ul style="list-style-type: none"> • Toronto North Support Services 	<ul style="list-style-type: none"> • Service will provide short-term ICM following engagement with the Toronto Central CCAC Complex Transitions Team, both to: <ul style="list-style-type: none"> ○ Provide a bridge to long-term services for which there is a wait ○ Facilitate flow through the Toronto Central CCAC Complex Transitions Team
<ul style="list-style-type: none"> • Begin operations 	Month 5	<ul style="list-style-type: none"> • Toronto Central CCAC • Toronto North Support Services 	<ul style="list-style-type: none"> • Toronto Central CCAC to access services via the partnership and protocol developed with Toronto North Support Services

5.2 Resource Requirements

The Advisory Committee developed preliminary cost estimates for implementation of the framework and associated recommendations. For the pilot projects, costs are provided for six months of operation. The cost to implement the Committee’s recommendations on a pilot / 6 month basis is approximately \$ 1,072,550. Some pilot projects, once initiated cannot be completely “turned off.” In these cases, on-going costs for maintaining what has been initiated

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were identified. Annualized, the cost to implement the framework and associated recommendations is **\$ 1,955,100**.

Staffing costs are only included for specific enhancements. No costs have been included for participation in training or for LHIN/agency staff that, in the context of their on-going responsibilities, are participating on Committees and Work Groups to guide implementation.

Costs for all FTE's have been calculated on the basis of \$100,000 per year for salary and benefits³⁰. People recruited to work on the pilots will require well developed skills in their area of focus, as well as the capacity to plan, initiate, monitor and report on new pathways of care.

Framework component	Sub-component/ recommendation	Cost Estimate 6 months	Cost Estimate Annualized	Comments
	Creation of a specialized behavioural unit in a LTC Home in the Toronto Central LHIN	\$262,500 5 FTEs for six months \$20,000 Space	\$525,000	12-15 people to be served Adjust skill mix through enhanced staffing levels: Day shift add - 3 FTEs – 1 NP, 1 RN and 1 other (combination of Behavioural OT, Recreation Specialist and Social Worker) Evening shift add - 1 FTE – RN Night Shift add - 1 FTE - RN One time costs re: minor space modifications (\$20,000) Initial training for whole unit – approximately 2 days per person, some on-the-job – not costed as this is only a preliminary estimate
	Enhancement of existing Geriatric Mental Health Outreach Team(s)	\$100,000 2 FTEs for six months \$1,200 Travel \$15,600 Medical costs	\$200,000 \$2400 \$31,200	6 Month Pilot 2 FTE's Medical staff costs (non OHIP billable): 10 hours per month @\$130.00/hr x 2 doctors Travel costs – will vary depending on scope of expansion; approx. \$2,400 / year for mileage, parking

³⁰ Except for the Nurse Practitioner for the Specialized Behavioural Unit which was estimated at a cost of \$125,000.

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Framework component	Sub-component/ recommendation	Cost Estimate 6 months	Cost Estimate Annualized	Comments
	Enhancement of the Developmental Services system's capacity to support 4 individuals with dual diagnosis in high-support settings	\$275,000 \$25,000 - \$50,000	\$550,000 (for 4 people)	One time costs for renovation (e.g., creating safe spaces for clients, staff offices, outdoor space, etc.; these spaces are created to address the needs of particular individuals and hence the costs to do so may vary) Property acquisition costs not included; ongoing occupation costs included Developing program protocols and training staff Ongoing annual costs Staffing – 24/7 Occupancy costs Food Transportation Offset by client co-payment (ODSP minus Personal Needs Allowance)
	Increasing access to high-support housing for ALC patients	\$27,000 10 rent supplements for six months \$50,000 1 FTE for six months	\$154,000	Rent supplement per person per year \$5400 per year Support costs for 10 - 1FTE Note – funding cannot be taken away – but can observe pilot to determine if this could be an effective longer-term access-optimization strategy
	Increasing of access to transitional intensive case management in the community for ALC patients	\$50,000 1FTE for six months	\$100,000	1 FTE for six months

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Framework component	Sub-component/ recommendation	Cost Estimate 6 months	Cost Estimate Annualized	Comments
Education and capacity-building Formal, consistent policies and processes System management and evaluation Advocacy for ongoing capacity enhancement Tools and templates	N/A	\$50,000 1 FTE for six months	\$50,000 0.5 FTE	LHIN staff and representatives of service providers on committee to guide development of materials 1 FTE for six months to support/coordinate this work and the development of policies, tools and templates On-going: .5 FTE at LHIN or selected agency to maintain the implementation of what has been developed
Expenses to support implementation all of the above recommendations	N/A	\$71,250	\$142,500	Estimated to be 10% of the FTE-related costs associated with implementation of each recommendation – telecom, IT, supplies, incidental travel, printing, meeting expenses
Expenses to support evaluation of implementation all of the above recommendations	N/A	\$100,000	\$200,000	

5.3 Key Messages for Communication Plan

In the process of developing this report and recommendations, people commented on their scanty, sometimes inadequate knowledge about policies, procedures and processes related to Alternate Level of Care. Questions frequently asked included:

- If an ALC patient or family has an appropriate destination in mind (i.e., close to where family lives / works, or that is can serve people in their first language) is it reasonable to ask the person / family to move to an interim location, if the waiting list is long?
- Can hospitals ask ALC patients for a co-payment if they aren't prepared to work with staff to find a suitable alternative? Should they?

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- Can supportive housing providers or LTCHs turn people down because they have been declared “not criminally responsible” for arson or manslaughter sometime in their past? Or if they are affiliated with the forensic mental health system for other reasons?
- If the alternate destination for someone who is ALC does not exist at all, can a person be considered ALC?
- If the destination exists, but the wait is 3 years, what are hospitals supposed to do?

All of these questions, and many more, confound patients, family members and health care workers who are trying to address a serious, and costly, health system issue.

A number of the recommendations in this report already include an emphasis on communication, to ensure that people know what is expected of them. A similar emphasis must be applied to the ALC Initiative as a whole to explain:

- Why and how it is a problem when patients remain ALC too long
- The Ministry of Health and Long Term Care’s priority on reducing the amount of time people remain ALC
- The policies and procedures that patients and hospitals are expected to follow; and
- How to appeal decisions that are made by the various parts of the system.
- It has already been noted that the recommendations in this report can address many of the issues and challenges involved with transitioning clients to a more appropriate level of care, but that they are incomplete without an increased supply of high support housing and residential options to address needs. The same can be said with respect to clear and frequent communication about ALC and why we need to address it.

6.0 CONCLUSION

Patients with mental health and addiction needs generally, and especially those who demonstrate severe, complex and challenging behaviours, experience long waits in hospital before transitioning to their next level of care, and face significant challenges getting there. This is not an acceptable situation.

Earlier this year, the Toronto Central LHIN contracted with the Centre for Addiction and Mental Health, with support from a cross-sectoral Advisory Committee, to:

- Transition 30 long-stay ALC patients with severe behavioural issues and dual diagnosis from TC LHIN hospitals to a more appropriate level of care

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- Develop a comprehensive plan for the ongoing care and management of individuals with severe behavioural issues and individuals with dual diagnosis in the TC LHIN
- Address issues surrounding the ongoing care of seniors with mental illness and addictions through the health continuum, developed through a Think Tank format and process.

This report provides an update on the status of patient transitions, outlines the various barriers experienced when attempting these transitions, and provides the Advisory Committee's best thinking as to the short-, medium- and long-term opportunities to make significant improvements in the patient and family experience during the transition process and to optimize patients' use and flow through the system's resources.

The Advisory Committee recommends strongly that wherever appropriate, the recommendations made in this report be implemented as demonstration projects and/or be linked with the province's Behavioural Support Strategy. This is to prevent the creation of additional silos within the system through the launch of independent, unlinked initiatives.

The Advisory Committee looks forward to continuing our work together and with the Toronto Central LHIN on this most important issue and supporting the implementation of the recommendations we have made.

APPENDIX A: MHA ALC Advisory Committee Terms of Reference

Background:

Alternate Level of Care (ALC) is a term used to describe hospital patients who face barriers to discharge although the level of care provided is no longer necessary. Patients waiting in ALC for longer than 30 days (“long-stay”) account for 13% of ALC discharges in the Toronto Central LHIN (TC LHIN), and yet represent over 50% of ALC days, signalling that a small proportion of people are using a large proportion of ALC days.

Through the work of the TC LHIN’s Long-Stay ALC Task Force, and subsequent long-stay patient reviews conducted by the Toronto Central CCAC, specific patient populations have been identified as requiring a system-wide approach to their care and their transitions along the care continuum. Individuals with severe behavioural management issues, including individuals with dual diagnosis (mental health needs and developmental disability) are two special population groups that have been identified.

The Toronto Central CCAC’s review of these two populations in the TC LHIN found that there is a lack of resources and specialized expertise to effectively support the care needs of these two groups in the community, resulting in delayed discharge and ALC designation. To address the needs of these groups, cross-continuum, population-specific strategies that leverage existing expertise, enable effective transition planning and provide for the specialized supports required in all destinations, are required.

Purpose:

A Mental Health and Addictions (MHA) Alternate Level of Care (ALC) Advisory Committee has been convened to develop and implement a comprehensive plan for the ongoing, care and management of individuals with severe behavioural issues and individuals with dual diagnosis in the Toronto Central LHIN.

The Advisory Committee will inform and contribute to the following deliverables:

- 1) Transitioning thirty (30) identified, existing long-stay ALC patients with severe behavioural issues and dual diagnoses from TC LHIN hospitals to a more appropriate level of care
- 2) Developing a comprehensive plan for the ongoing care and management of individuals with severe behavioural issues and individuals with dual diagnosis in the

TC LHIN. More specifically, the Advisory Committee will build on the Toronto Central CCAC's Long-Stay ALC Task Group work and recommendations, to develop:

- A framework/model that organizes and manages the continuum of services for each population group, for example:
 - Partnerships and mechanisms to support inter-sectoral collaboration
 - Inter-provider communication strategies including “access to experts”
 - Inventories of service options available to patients, families and referral sources
 - A hospital-based strategy that will identify and manage at risk individuals to prevent them from being designated ALC and ensure timely transitions to the most appropriate destinations
 - The cost of sustainability of care/services for this population
- 3) Addressing issues surrounding the ongoing care of seniors with mental illness and addictions through the health continuum, developed through a Think Tank, to be organized and led by CAMH

Required Outcomes

Short-term outcomes include:

- A. The transition of 30 long-stay ALC patients (from a population of 20 individuals with severe behavioural management issues and 10 individuals with dual diagnosis) reviewed during the CCAC's intensive case management review to their next most appropriate level of care (with the transition planning process to be underway by March 31, 2011)
- B. Development and initial implementation of a comprehensive, sustainable approach to the ongoing care and management of individuals with severe behavioural issues and individuals with dual diagnosis across the continuum of care in the TC LHIN (i.e., all individuals, not only the 30 long-stay ALC patients identified above)
- C. A Think Tank session resulting in specific recommendations for improving transition of seniors through the continuum of care and preventing ALC designations for this population.

Term

The Advisory Committee will function on a time-limited basis. Upon completion of the deliverables outlined above, the Advisory Committee will be disbanded.

Membership

Membership will include representation from the following:

- Acute care/CCC/Rehab hospitals
- Long Term Care
- Assisted living
- Supportive housing
- Specialized dual diagnosis services
- Ministry of Community and Social Services – Developmental Services
- Consumers
- Families
- Toronto Central CCAC
- Toronto Central LHIN

The Advisory Committee will be chaired by Dr. Catherine Zahn, President and CEO, Centre for Addiction and Mental Health (CAMH). CAMH will facilitate and support the meetings.

Meeting invitations will be extended to relevant stakeholders (i.e., subject matter experts) where agenda items warrant additional perspective beyond core Advisory Committee members. The Advisory Committee will establish Sub-Committees and Working Groups as needed to achieve its deliverables.

Accountability

The Task Group will be accountable to the TC LHIN through CAMH, as project lead.

The plan for the ongoing care and management of individuals with severe behavioural issues and individuals with dual diagnoses will be submitted to the TC LHIN's Mental Health and Addictions Sector table and to the Hospital Sector table for review and approval.

Meetings

The meeting schedule will be determined to facilitate implementation of the Advisory Committee's workplan.

APPENDIX B: MHA ALC Advisory Committee Membership

MEMBER	CONTACT INFORMATION
<p>Catherine Zahn (Chair) President and CEO Centre for Addiction and Mental Health (CAMH)</p>	<p>Centre for Addiction and Mental Health (CAMH) 901 King St. W, 5th Floor Toronto, ON M5V 3H5 Office: 416-535-8501, ext. 6076 Email: catherine_zahn@camh.net anna_chow@camh.net</p>
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<p>Anne Stephens Clinical Nurse Specialist Toronto CCAC</p>	<p>Toronto Central CCAC 250 Dundas Street West, Suite 305 Toronto, Ontario M5T 2Z5 Office: 416-506-9888 ext. 2613 Email: anne.stephens@toronto.ccac-ont.ca</p>
<p>Wendy Cameron Practice Leader, Social Work Clinical Lead Bridgepoint Health</p>	<p>Bridgepoint Health 14 St. Matthews Road Toronto, ON M4M 2B5 Office: 416-461-8252 ext. 2213 Email: wcameron@bridgepointhealth.ca</p>
<p>Rohan Ganguli EVP, Strategic Transformation Initiatives & Clinical Quality Improvement CAMH</p>	<p>Centre for Addiction and Mental Health (CAMH) 901 King St. W, 5th Floor Toronto, ON M5V 3H5 Office: 416-535-8501 ext. 6106 Email: rohan_ganguli@camh.net lydia_barrett@camh.net</p>
<p>Catherine Petch <i>(replaced mid-term by Marilyn Wharton)</i> Chief Nurse Executive Director of Professional Practice and Programs Clinical Lead – CCAC Project Toronto Grace Health Centre</p>	<p>Toronto Grace Health Centre 650 Church Street Toronto, ON M4Y 2G3 Office: 416-925-2251 ext. 224 Email: cpetch@torontograce.org</p>

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<p>Sandra (Sandi) Bricker Surrey Place Centre Toronto Community Network of Specialized Care for Dual Diagnosis</p>	<p>Surrey Place Centre 2 Surrey Place Toronto, ON M5S 2C2 Office: 416-925-5141 x2731 Email: sandra.bricker@surreyplace.on.ca</p>
<p>Manuela Dalla-Nora Executive Director Vita Community Living Services of Toronto Inc.</p>	<p>Vita Community Living Services Of Toronto Inc 4301 Weston Road ON Toronto, ON M9L 2Y3</p>
<p>John Flannery CEO Surrey Place Centre</p>	<p>Surrey Place Centre 2 Surrey Place Toronto, ON M5S 2C2 Office: 416-925- 5141 ext. 2387 Email: john.flannery@surreyplace.on.ca shashi.ponnappa@surreyplace.on.ca</p>
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<p>Kerry-Ann Markle Program Supervisor, Developmental Services Ministry of Community and Social Services, Toronto Region</p>	<p>Ministry of Community and Social Services, Toronto Region 477 Mount Pleasant Road, 3rd Floor Toronto, ON M7A 1G1 Office: 416-325-0651 Email: kerryann.markle@ontario.ca</p>

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<p>Jim McMinn Program Director - John Gibson House and the Stepping Stone Project LOFT Member, Review Team for Long Stay ALC Review and Intensive Case Management</p>	<p>LOFT 15 Toronto Street, 9th Floor Toronto, ON M5C 2E3 Office: 416-537-3477 ext. 222 Email: jmcminn@loftcs.org</p>
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<p>Vija Mallia Administrator Castleview Wychwood Towers</p>	<p>Castleview Wychwood Towers 351 Christie Street Toronto ON M6G 3C3 Office: 416-392-5700 Email: VMALLIA@toronto.ca</p>
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<p>Jan Lackstrom Clinical Director, Departments of Psychiatry, Spiritual Care, Family and Community Health and Allied Health, University Health Network</p>	<p>University Health Network Toronto Western Hospital site 399 Bathurst Street Toronto, ON M5T 2S8</p> <p>Office: 416 603-5800 ext. 2796 Email: Jan.Lackstrom@uhn.on.ca</p>
<p>Ian Dawe (<i>resigned mid-term</i>) Medical Director, Psychiatric Emergency Service, St. Michael's Hospital</p> <p>Medical Director, Toronto Mental Health & Addictions Emergency Department Alliance</p>	<p>St. Michael's Hospital 30 Bond Street Toronto ON M5B 1W8</p> <p>Office: 416-864-5137 E-Mail: DAWEI@smh.ca</p>
<p>Marilyn Wharton Executive Director Patient Care Toronto Grace Health Centre</p>	<p>Toronto Grace Health Centre 650 Church Street Toronto, ON M4Y 2G3</p> <p>Office: 416-925-2251 ext. 19 Email: mwharton@torontograce.org</p>
<p>Marci Rose Administrative Director, Department of Psychiatry, Mount Sinai Hospital</p>	<p>Mount Sinai Hospital Joseph and Wolf Lebovic Health Complex 600 University Avenue Toronto, ON M5G 1X5</p> <p>Office: 416-596-4200 ext. 5906 Email: mrose@mtsinai.on.ca</p>

APPENDIX C: Definitions of Developmental Disability and Dual Diagnosis

Developmental disability

For the purposes of this report, the Advisory Committee used the following definitions of developmental disability to guide its work:

“Children, youth and adults with developmental disabilities have significantly greater difficulty than most people with intellectual and adaptive functioning and have had such difficulties from a very early age (or the developmental period prior up to age 18).

“Adaptive functioning” means carrying out everyday activities such as communicating and interacting with others, managing money, doing household activities and attending to personal care.

Developmental disabilities include developmental disorders such as Fetal Alcohol Spectrum Disorders or autism with significant impairment in adaptive living skills.”

National Coalition on Dual Diagnosis, 2008

“3. (1) A person has a developmental disability for the purposes of this Act if the person has the prescribed significant limitations in cognitive functioning and adaptive functioning and those limitations,

- a) originated before the person reached 18 years of age;
- b) are likely to be life-long in nature; and
- c) affect areas of major life activity, such as personal care, language skills, learning abilities, the capacity to live independently as an adult or any other prescribed activity.

“Adaptive functioning” means a person’s capacity to gain personal independence, based on the person’s ability to learn and apply conceptual, social and practical skills in his or her everyday life.

“Cognitive functioning” means a person’s intellectual capacity, including the capacity to reason, organize, plan, make judgments and identify consequences.”

Bill 77 (Chapter 14 Statutes of Ontario, 2008)

Dual diagnosis

For the purposes of this report, the Advisory Committee used the following definitions of dual diagnosis to guide its work:

“Persons with dual diagnosis live with mental health difficulties in addition to a developmental disability.”

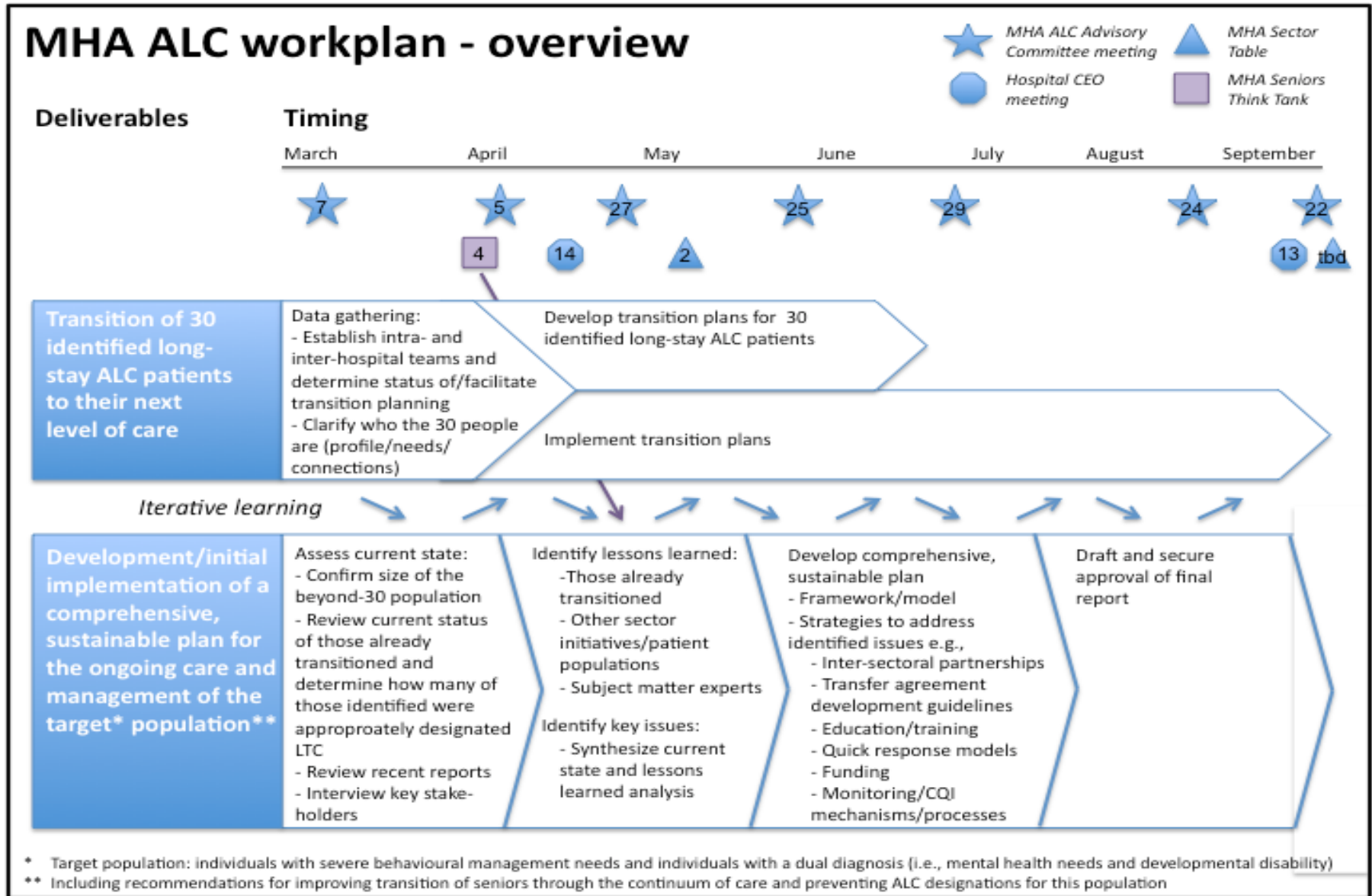
National Coalition on Dual Diagnosis, 2008

“Adults with a Dual Diagnosis” are those persons 18 years of age and older with both a developmental disability and mental health needs.

For the purposes of this Dual Diagnosis Guideline, “mental health needs” are defined as diagnosed mental illness or symptoms consistent with mental illness.”

Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis, December 2008

APPENDIX D: MHA ALC Advisory Committee Workplan



MHA ALC workplan - detail

Deliverable	Activity	Detailed activity	Timing	Lead	
Transition of 30 identified long-stay ALC patients to their next level of care	Data gathering	<ul style="list-style-type: none"> Establish intra- and inter-hospital teams and determine status of and facilitate transition planning Meet with intra-hospital teams to facilitate transition planning and implementation Convene inter-hospital team to share successes, challenges, lessons learned and brainstorm opportunities/solutions 	<ul style="list-style-type: none"> ASAP Mid-March, ongoing Early-mid April; late May/early June 	<ul style="list-style-type: none"> Anne Hertz 	
		<ul style="list-style-type: none"> Clarify who the 30 people are (profile/needs/connections) <ul style="list-style-type: none"> Review/address any issues/questions re: CCAC review Review profiles of the 30 individuals to identify commonalities, differences, issues to address (e.g., dual diagnosis designation – appropriate or not; whether person needs to go through the community designation process or not) and current connections (e.g., connected already with MCSS or not) Survey hospitals (e.g., Psychiatry/GIM) as to current status of the identified 30 individuals 	<ul style="list-style-type: none"> Mid-late March Late March 	<ul style="list-style-type: none"> Anne Hertz Toronto CCAC reps Anne Hertz 	
	Develop transition plans for 30 identified long-stay ALC patients	<ul style="list-style-type: none"> Review historical and most recent client information and develop plan to transition clients to their next level of care Participate in intra-hospital team to share successes, challenges, lessons learned and brainstorm opportunities/solutions 	<ul style="list-style-type: none"> ASAP and ongoing Early-mid April; late May/early June 	<ul style="list-style-type: none"> Inter-hospital teams Inter-hospital teams 	
	Implement transition plans	<ul style="list-style-type: none"> Begin and monitor implementation of transition plans 	<ul style="list-style-type: none"> ASAP and ongoing 	<ul style="list-style-type: none"> Inter-hospital teams 	

MHA ALC workplan – detail (cont'd)

Deliverable	Activity	Detailed activity	Timing	Lead
Development/ initial imple- mentation of a comprehensive, sustainable plan for the ongoing care and management of the target population	Assess current state	<ul style="list-style-type: none"> Estimate the size of the beyond-30 population 	<ul style="list-style-type: none"> Late March 	<ul style="list-style-type: none"> Adair Roberts
		<ul style="list-style-type: none"> Review current status of already transitioned (e.g., have they remained in designated level of care/placement or not) 	<ul style="list-style-type: none"> Late March/ early April 	<ul style="list-style-type: none"> Anne Hertz, CCAC reps
		<ul style="list-style-type: none"> Determine how many of those identified were appropriately designated LTC or not and identify any commonalities among the misdesignated (if any) patients 	<ul style="list-style-type: none"> Late March 	<ul style="list-style-type: none"> Anne Hertz, CCAC reps
		<ul style="list-style-type: none"> Review recent reports <ul style="list-style-type: none"> CCAC report Value and Affordability Task Force Guidelines for Dual Diagnosis CAMH Policy Department materials Health System Consulting Research Unit documents 	<ul style="list-style-type: none"> Late March/ early April 	<ul style="list-style-type: none"> Adair Roberts
		<ul style="list-style-type: none"> Interview key stakeholders (to be determined) 	<ul style="list-style-type: none"> Late March – mid-April 	<ul style="list-style-type: none"> Adair Roberts, Anne Hertz
	Identify lessons learned	<ul style="list-style-type: none"> Review cases of those already transitioned (characteristics of patients/populations; original/review-based designations; what worked, what didn't to support a person's successful transition Review characteristics of successful transitions (commonalities, differences, key success factors, challenges) Develop case examples 	<ul style="list-style-type: none"> Late March – mid-April Late-March- mid-April Early April 	<ul style="list-style-type: none"> Anne Hertz, CCAC reps Anne Hertz, CCAC reps Anne Hertz
		<ul style="list-style-type: none"> Review other sector initiatives/patient populations <ul style="list-style-type: none"> Wait times/Pay-for-Performance initiatives Value and Affordability Task Force Aging at Home initiatives Dual Diagnosis specialized treatment beds example Seniors MHA Think Tank results Other (to be determined) 	<ul style="list-style-type: none"> Late March – mid-April April 4 	<ul style="list-style-type: none"> Adair Roberts

MHA ALC workplan – detail (cont'd)

Deliverable	Activity	Detailed activity	Timing	Lead
Development/ initial imple- mentation of a comprehensive, sustainable plan for the ongoing care and management of the target population (cont'd)	Identify lessons learned (cont'd)	<ul style="list-style-type: none"> • Interview subject matter experts • Networks of Specialized Care Planning Session/Day • John Flannery • Manuela Dalla Nora • Other (to be determined) 	• Late March – mid-April	• Adair Roberts
	Identify key issues	<ul style="list-style-type: none"> • Synthesize current state and lessons learned analysis (e.g., by developing transition case examples as a vehicle through which to identify key issues) • Review synthesis and identify key issues • Develop preliminary strategies to address identified issues - e.g., • Develop principles to guide strategy development and implementation • Develop transition planning guidelines • Review existing/develop transfer agreement guidelines • Collate “best practice” education materials/methods • Document potential “quick response/back-up” models • Other (to be determined) 	<ul style="list-style-type: none"> • Late April • Late April • Early-mid May 	<ul style="list-style-type: none"> • Adair Roberts • ALC AC • Adair Roberts, ALC AC
	Develop compre- hensive, sustainable plan	<ul style="list-style-type: none"> • Design a draft framework/model that organizes and manages the continuum of services for each population group, including: • Partnerships and mechanisms to support inter-sectoral collaboration • Inventories of available service options • Inter-provider communication strategies including “access to experts” • Hospital-based strategies that will identify and manage at-risk individuals to prevent them from becoming ALC and ensure timely transitions to the most appropriate destinations • Funding needed to ensure sustainability of the framework • Monitoring/CQI mechanisms/processes • Refine and finalize the framework/model 	<ul style="list-style-type: none"> • May-June • Late June 	<ul style="list-style-type: none"> • Adair Roberts, ALC AC • ALC AC

MHA ALC workplan – detail (cont'd)

Deliverable	Activity	Detailed activity	Timing	Lead
Development/initial implementation of a comprehensive, sustainable plan for the ongoing care and management of the target population (cont'd)	Draft and secure approval of final report	<ul style="list-style-type: none"> • Prepare and submit reports to TC LHIN Mental Health and Addictions Network • Prepare and submit reports to the Hospital CEO's Table • Draft final report • Review draft report with ALC AC • Refine and finalize final report • Submit report to the Hospital CEO's Table • Submit report to the TC LHIN 	<ul style="list-style-type: none"> • April 7, late June, early September • April 14, September 13 • July – mid-August • Late August • Late August • September 13 • Late September 	<ul style="list-style-type: none"> • Adair Roberts, ALC AC • Adair Roberts, ALC AC • ALC • Adair Roberts • ALC AC • ALC AC

APPENDIX E: Excerpts from the Final Report of the Seniors' Think Tank

Foundational Strategies and System-Wide Operating Principles

1. Support prevention and early intervention.
2. Be respectful of ethno-cultural or ethno-racial influences in help-seeking and service utilization.
3. Focus activities and resources on developing the capacity of the 'community' to provide care.
4. Be innovative and break traditional ways of working together so that the resulting whole is greater than the sum of the parts.
5. Enhance communication and smooth out transitions between hospital and community.
6. Continuously share and communicate information about the services that are available.

Specific Strategic Actions and Program Guidelines

1. Conduct integrated, comprehensive assessments with regular follow-up, improved tracking and co-ordination of client information.
2. Create customized, client-centred care plans that actively involve the senior and their family in development of the plan.
3. Take the time to build trust in relationships and partnerships between service providers to ensure better integration of services and smooth transitions.
4. Provide supports that help break down barriers to accessing services such as those faced by seniors with no ID, those requiring interpretive services, and those living in locations with fewer services.
5. Apply an intensive case management framework for supporting high-needs seniors in the community.

Two other important actions:

- Increasing the number and availability of additional transitional-type units, similar to those already in place through the Stepping Stone Project, within the supportive housing sector;
- Supporting the creation of additional behavioural units and ongoing staff training and development in the Long-term Care sector.

Topic Areas and Ideas for Potential Projects and Initiatives

1. Education, training and information sharing:

- Build on and promote shared resource databases.
- Design education and cross-training programs for a range of stakeholders including caregivers/ family members.

2. Active partnering and collaboration with multiple stakeholders

- Build on collaborative care models and cross-sectoral partnerships between hospitals, the CCAC and community services to support transitions between services.
- Develop a “cluster” / wrap-around model that is inclusive, smoothes out transitions and keeps people from falling through the cracks.

3. Intensive community services and programs that support access to services

- Identify and build the capacity of “proven” services that provide intensive supports for seniors with mental health and addictions.
- Identify, support or develop and promote programs that support access to services such as ID clinics, interpretation services and flexible access models.

4. Individualized care and intensive case management

- Build and expand on existing integrated care models where case managers/ champions/advocates/system-navigators stay with a senior throughout their journey.

5. Early intervention

- Leverage existing data sources and reports to better understand who is at risk of being designated ALC.
- Develop common criteria for community programs to be able to identify at risk clients in the community and provide necessary support to prevent deterioration and hospitalization.
- Develop respite support for caregivers living with seniors with MH&A issues in order to adequately support caregivers and reduce burnout.

Recommendations to the TC LIN for Initial Actions

1. Leveraging existing knowledge transfer networks, develop a knowledge exchange strategy to further promote current centralized information sources and increase the level of information sharing between practitioners, caregivers, families and seniors.
2. Prioritize capacity building of community-based, specialized intensive services focused on seniors with MH&A issues to allow for effective transitioning of seniors with MH&A issues who have been designated ALC out of hospitals and into the appropriate community supports. Such services might include the creation of additional transitional beds in supportive housing or additional behavioural units in long-term care homes. Regardless of the project endorsed, linkages with formal specialty geriatric mental health and addiction services will be vital.
3. Establish a TC LHIN coordinated, multi-stakeholder seniors mental health and addictions committee that can act as a knowledge exchange vehicle, and has the mandate to discuss and address barriers to care, develop strategic initiatives and report back to the community.
4. Review available data and reports to understand the profile of seniors who are consistently designated ALC. Share the lessons learned with the community of practitioners and use the data to guide the development of appropriate community services.

APPENDIX F: Current Status of and Lessons Learned from Identified Long-Stay ALC Patients

Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
Male, age 92 ALC <1 yr	<ul style="list-style-type: none"> • Fluctuating behaviours – exit-seeking and verbal/some physical abuse related to exit-seeking • Requires secure unit and 3-5 hours of care / day • Wheelchair for mobility • Ulcers, incontinent 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Behavioural challenges –fluctuating behaviours cause LTCHs to re-assess suitability 	Discharged to Kensington Gardens LTC facility in December 2010	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed
Female, age 34 ALC 1 yr	<ul style="list-style-type: none"> • Anxious, repetitive speech, schizophrenia • Incontinent – bilateral urostomy tubes that require regular monitoring of dressing • Nephrostomy tubes attached to leg bags 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Limited number of choices, all with long wait 	Discharged to LeisureWorld St. George LTC facility in March 2011	<ul style="list-style-type: none"> • Need for formal, consistent ALC policies and processes to support discharge planning
Male, age 65 ALC 1.5 yr	<ul style="list-style-type: none"> • Parkinson’s and developmental delay • Impaired cognition • Incontinent 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Client/family unwilling to participate in discharge planning • Limited number of choices, all with long wait 	Discharged to Senior’s Health LTC facility in February 2011	<ul style="list-style-type: none"> • Need for formal, consistent ALC policies and processes to support discharge planning
Male, age 44 ALC 10+ yrs	<ul style="list-style-type: none"> • Verbally abusive, stroke • Anxious, suspicious, resistive, OCD traits – becomes angry if tasks are not carried out exactly, demanding • Smoker 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Limited number of choices, all with long wait • Slow response time of LTC facilities Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Concerns re: behaviours 	Discharged to Castleview LTC facility in July 2011	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes to support discharge planning

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
		<ul style="list-style-type: none"> • Young for LTC setting 		
Female, age 61 ALC 1.5 yr	<ul style="list-style-type: none"> • Cirrhosis due to Vitamin A toxicity • Depression • Multiple other problems • Requires 3-5 hours care / day • Rollator or wheel chair for mobility • Verbally abusive – swearing, racist remarks – normally related to having to wait for assistance 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Concerns re: behaviours Patient/family unwillingness to move <ul style="list-style-type: none"> • Limited number of choices, all with long wait 	Discharged to Chester Village LTC facility in June 2011	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes to support discharge planning
Female, age 80 ALC <1 yr	<ul style="list-style-type: none"> • Cognitive impairment • Frequent urinary incontinence • Wheel chair for mobility • Agitated during the day, related to trying to exit unaccompanied (not permitted) • Requires more than 5 hours care / day • Wandering and exit seeking behaviour – needs secure unit 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Limited number of choices, all with long wait Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Concern re: placement in LTC 	Discharged to Cedarvale LTC facility in December 2010	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes to support discharge planning
Male, age 44 ALC 11 yrs	<ul style="list-style-type: none"> • HIV dementia • Behaviours – verbally abusive, refuses Rx, alleged on-going substance use (marijuana), alleged sharing substances with other patients, poor hygiene with refusal to shower, can be verbally abusive, swearing, hoarding • Requires 3-4 hours of care / day • Wheelchair for mobility • ALC discontinued for a time due to kidney stones 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Concerns re. behaviours • Patient has been rejected by multiple homes, multiple times Patient/family unwillingness to move <ul style="list-style-type: none"> • Limited number of choices, all with long wait Lack of adherence to established policies, processes	Awaiting LTC placement	<ul style="list-style-type: none"> • Need for formal, consistent policies re: role of service providers

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	<ul style="list-style-type: none"> • Neuropathy, pain management • Smoker – independent 	<ul style="list-style-type: none"> • Confusion on the part of LTCHs re. how to handle client's smoking 		
Male, age 47 ALC 2 yrs	<ul style="list-style-type: none"> • Schizophrenia, seizure disorder – frequent seizures • Bed went to a crisis placement 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Rejected Insufficient inter-sectoral collaboration <ul style="list-style-type: none"> • PGT delay in choosing facilities 	On three LTC waiting lists	<ul style="list-style-type: none"> • Need for formal, consistent ALC policies and processes to support discharge planning • Need for inter-sectoral service coordination
Female, age 88 ALC 2 yrs	<ul style="list-style-type: none"> • Cirrhosis due to vitamin A toxicity • Dementia and wandering • Requires support for ADL / transfers, manual wheelchair and routine toileting to maintain continence • Frequent transfers to acute care to treat infections (urinary tract) • Can be physically abusive; has hit staff • Patient wanders into other people's rooms, takes belongings 	Care settings – insufficient skills or confidence Patient/family unwillingness to move <ul style="list-style-type: none"> • Restraints use – family wants availability due to risk of falls, but LTC restraint free 	Patient recently returned from acute care and is not currently ALC	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes to support discharge planning
Female, age 65 ALC 3 yrs	<ul style="list-style-type: none"> • MS • In/out catheterization – x3 daily – RN required to perform • Behaviour challenges • Smoker 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Difficult to place because of catheterization • Concerns re. behaviours 	Discharged to Ina Grafton in August 2011	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed and management of intermittent catheterization
Male, age 60 ALC 3 yrs	<ul style="list-style-type: none"> • Schizophrenia, ABI, dementia, diabetes, w/c for mobilization • Unpredictable outbursts-yells, 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Sister refused for many years to submit LTC papers 	Discharged to Cumber Lodge LTC facility in February 2011	<ul style="list-style-type: none"> • Need for formal, consistent ALC policies and processes to support discharge planning

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	screams, name calling, appears physically threatening but no recent history (+20 yrs) of physical aggression, short attention span	<ul style="list-style-type: none"> Resistant to choosing short list facility 		
Male, age 53 ALC 1+ yr	<ul style="list-style-type: none"> Family history – SCZ Smoker, wanders, behaviour issues (can be aggressive), cognitive impairment History of arson Needs hip replacement but family refuses – requires support for ADL and uses cane Initially, no income or OHIP (immigration status) therefore unable to pay 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> Discharge re-scheduled several times <p>Patient/family unwillingness to move</p> <ul style="list-style-type: none"> Family not prepared to consider ANY options, although now on OHIP and able to pay 	Team made arrangements for client discharge to supportive housing but displayed aggressive behaviour at assessment interview and subsequently denied	<ul style="list-style-type: none"> Capacity enhancement for behaviour management needed Need for formal, consistent ALC policies and processes to support discharge planning
Female, age 44 ALC 1+ yr	<ul style="list-style-type: none"> Cognitive impairment, substance abuse, diagnosis of schizophrenia, some developmental disability Smoker History of arson – NCR 2003 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> On waiting list; passed over 2x in favour of a placement from community <p>Insufficient inter-sectoral collaboration</p> <ul style="list-style-type: none"> Initially thought client had dual diagnosis and/or was eligible for LTC; not eligible for either, so now placement being pursued in mental health supportive housing 	Team has put in application through CASH and client is on 3 wait lists	<ul style="list-style-type: none"> Capacity enhancement for behaviour management needed Need for inter-sectoral service coordination
Male, age 45 ALC 1.5 yr	<ul style="list-style-type: none"> Diagnosis of SCZ History of fraud, assaults, possession of narcotics Challenging behaviours – 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> Initially, active drug use prevented discharge 	Discharged to 2140 Bloor (Habitat) in April 2011	<ul style="list-style-type: none"> Need for inter-sectoral service coordination

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	<p>inappropriate sexually and frequent screaming</p> <ul style="list-style-type: none"> • Substance abuse issues • Smoker 			
<p>Male, age 65 ALC 2+ yrs</p>	<ul style="list-style-type: none"> • Personality disorder • Cognition consistent with Schizoaffective Disorder • History of arson • Needs supervision for smoking • Medical issues – heart problems, diabetes, hypertension, anaemia • History of arson – ORB order prohibits access to incendiary devices which will be difficult to monitor in community • Needs ORB approval for location 	<p>Patient/family unwillingness to move</p> <ul style="list-style-type: none"> ○ Has selected one location and unwilling to consider others 	<p>Waiting for Chai Tikvah – long waiting list</p> <p>Discussion re. possible need to charge client to remain in hospital</p>	<ul style="list-style-type: none"> • Need clear pathway and high quality discharge and transition planning process in place • Need for formal, consistent ALC policies and processes to support discharge planning
<p>Male, age 46 ALC <1 yr</p>	<ul style="list-style-type: none"> • History of violence – NCR for manslaughter in 2004 • Challenging behaviours – sexually inappropriate • Some medical issues – hypertension, metabolic syndrome • Vietnamese speaking with limited English • Smoker 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> ○ Concerns re: history, behaviours, and language ○ ORB approval required for any placement 	<p>Senior-level discussions held with housing / service providers to address the special needs – no locations lined up</p> <p>Commitment for on-going support from CAMH LAMH program</p>	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes to support discharge planning
<p>Male, age 23, ALC 1+ yrs</p>	<ul style="list-style-type: none"> • Severe autism and moderate/severe mental retardation • Severe behavioural issues – pinching, hitting, choking – triggered by loud 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> ○ Requires monitoring / support 24/7 	<p>Remains in CAMH Dual Diagnosis unit with round the clock monitoring / support</p>	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for inter-sectoral service coordination

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	<ul style="list-style-type: none"> noises OCD-like behaviours Smoker 	<ul style="list-style-type: none"> High cost <p>Insufficient availability of high-support housing</p>	<p>Kerry's place costing undertaken</p> <p>Discussion re. options with Network of Specialized Care</p>	<ul style="list-style-type: none"> For some clients, no appropriate ALC location exists; need for development of new models
<p>Male, age 79</p> <p>ALC 2+ yrs</p>	<ul style="list-style-type: none"> Medical issues Moderate/severe dementia Challenging behaviours – sometimes violent NCR for manslaughter in 2006 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> Concerns re. history, behaviours, and language <p>Patient/family unwillingness to move</p> <ul style="list-style-type: none"> Limited English (Portuguese speaking); incapable of making placement decisions and family in Portugal does not want to be involved in discharge 	<p>On-going medical issues resulting in visits to general hospital(s). Missed bed offer due to medical instability</p> <p>Discharged to O'Neil Centre in August 2011</p>	<ul style="list-style-type: none"> Capacity enhancement for behaviour management needed Need for inter-sectoral service coordination
<p>Male, age 60</p> <p>ALC 2+ yrs</p>	<ul style="list-style-type: none"> Involved with mental health system since the age of 17 Medically stable but insulin dependent and requires assistance for ADL Uses walker for mobility Challenging behaviours and occasional overnight absences 	<p>Patient unwillingness to move</p> <ul style="list-style-type: none"> Initially waiting for only one LTC Home and extremely resistant to considering other options Has subsequently been reassessed and considered ineligible for LTC 	<p>Efforts to engage client in pursuing other options not successful - no confirmed options</p> <p>Escalation to program management and psychiatrist to work with client to try and arrive at a plan that is agreeable to him</p>	<ul style="list-style-type: none"> Need for formal, consistent ALC policies and processes to support discharge planning
<p>Male, age 66,</p> <p>ALC 2+ yrs</p>	<ul style="list-style-type: none"> SCZ diagnosis at 19 and has been institutionalized for much of the time since Occasional but acute delusions 	<p>Patient/family unwillingness to move</p> <ul style="list-style-type: none"> Family adamant that client MUST go to Baycrest despite ongoing efforts to engage in exploring other 	<p>No confirmed options</p> <p>Escalation to physician-in-chief to work with family</p>	<ul style="list-style-type: none"> Need for formal, consistent ALC policies and processes to support discharge planning

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	<ul style="list-style-type: none"> • Can be sexually inappropriate – comments to females and exposes himself in public 	<ul style="list-style-type: none"> options <ul style="list-style-type: none"> ○ Recent CCAC decision that client is ineligible for LTC; family appealing 	– considering charging client to remain in hospital	
Male, age 54 ALC 2+ yrs	<ul style="list-style-type: none"> • In hospital since 1985 • Cognitive impairments – delusions and disorganized thoughts • Often agitated during the day, aggressive, physically abusive, exhibiting inappropriate sexual behaviour • Receives regular ECT to stabilize behaviours • Secure unit as precaution – concern that he will become disoriented 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Hospitalized for so long – concern that unable to function on his own 	In April 2011, physicians decide to revert client to non-ALC status due to risk concerns	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed
Female, age 33 ALC 2+ yrs	<ul style="list-style-type: none"> • SCZ • Incontinent; sometimes disruptive/resistive • Has no family or support group willing to be involved in discharge care 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Turned down by initial destination because client needed more support than they felt they could offer • Discharge re-scheduled several times 	Discharged to SHIP Brampton in late July 2011	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed
Female, age 57 ALC 1 yr	<ul style="list-style-type: none"> • SCZ, cognitive impairment, mild developmental delay • Occasional incontinence • Needs supervision bathing, eating, 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Destinations refusing (rejected by 4 destinations) 	Applied to Mens Sana and looks on track to be discharged in September	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	dressing <ul style="list-style-type: none"> • Sometimes resistant to treatment • Smoker 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Family wanted only Mon Sheong – Chinese-themed nursing home with a long waiting list 		to support discharge planning <ul style="list-style-type: none"> • Need for inter-sectoral service coordination
Male, age 40s ALC 4 yrs	<ul style="list-style-type: none"> • Schizophrenia, cognitive impairment, no insight • May be resistive • No family or support group 	Patient/family unwillingness to move <ul style="list-style-type: none"> • Turning down all options 	Discharged to SHIP Brampton in early August	<ul style="list-style-type: none"> • Need for formal, consistent ALC policies and processes to support discharge planning
Female, age 33 ALC 1+ yr	<ul style="list-style-type: none"> • Multiple mental health issues: severe borderline disorder, developmental delay, schizophrenia, autism, OCD • No insight • Consistently verbally abusive and can be physically abusive • Inappropriate sexual behaviour • Family unwilling to be involved in discharge care 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Concerns re. behaviours • Rejected from numerous non-LTC housing 	On waiting list for Kerry's Place but no discharge date (very long wait) Pending results of assessment, potential candidate for Griffin Centre	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for inter-sectoral service coordination
Male, age 49 ALC 1+ yrs	<ul style="list-style-type: none"> • Developmental disorder, NOS + schizophrenia; cognitive impairment • Aggressive; potential for injury to self or others; hoarding • Incontinence 	Care settings – insufficient skills or confidence <ul style="list-style-type: none"> • Concerns re. behaviours Patient/family unwillingness to move	On waiting list for Kerry's Place but no discharge date (very long wait) At top of list for	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for formal, consistent ALC policies and processes

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Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
	<ul style="list-style-type: none"> • Smoker • Requires supervision and a structured environment to live successfully in the community • Family unwilling to be involved in discharge care 	<ul style="list-style-type: none"> • Limited number of choices, all with long wait <p>Insufficient inter-sectoral collaboration</p> <ul style="list-style-type: none"> • Delays getting consent from PGT 	Regeneration House	<p>to support discharge planning</p> <ul style="list-style-type: none"> • Need for inter-sectoral service coordination
Female, age 23 ALC <1 yr	<ul style="list-style-type: none"> • Mild mental retardation (IQ under 70); cognitive impairment • Verbally and physically abusive • Inappropriate sexual behaviour 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> • ORB status 	<p>Discharged to Christian Horizons in March</p> <p>Subsequently re-admitted and no longer ALC</p>	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed
Male, age 63 ALC 1 yr	<ul style="list-style-type: none"> • Legally blind • Developmental disability (moderate retardation) • Bipolar • Autism • Self-injurious behaviours and aggression 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> • Destinations refusing 	No plan in place	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed • Need for inter-sectoral service coordination • For some clients, no appropriate ALC location exists; need for development of new models
Female, age 80	<ul style="list-style-type: none"> • Behaviours and resistive to care 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> • Concern re: effectiveness of medication changes – discussions re: suitability of 	Discharged in March	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed

Patient	Description of primary needs	Primary barriers to transition	Current status	Lessons learned for longer-term plan development
		<p>Long-Term Care versus high-support supportive housing</p> <p>Patient/family unwillingness to move</p> <ul style="list-style-type: none"> • Limited number of choices 		
Male	<ul style="list-style-type: none"> • Incontinent and needs feeding tube • Wheelchair for mobility – can go only short distances on his own • Areas of skin-grafting are prone to breakdown – wound care required • Intellectually challenged and requires frequent redirection, reassurance and cueing • Verbally and physically disruptive/abusive • Needs more than 5 hours of care per day 	<p>Care settings – insufficient skills or confidence</p> <ul style="list-style-type: none"> • Concern re: behaviours and range of physical needs – difficult to find receiving organization that can address them all • No family supports in the community who are willing to be involved in the patient’s discharge 	Physicians decide to revert client to non-ALC status due to health concerns	<ul style="list-style-type: none"> • Capacity enhancement for behaviour management needed

APPENDIX G: Background Documents Used in the Preparation of this Report

Alternate Level of Care

- The Long Stay Alternate Level of Care (ALC) Review and Intensive Case Management Project in the Toronto Central LHIN: Final Report – Toronto CCAC, January 2011
- Provincial ALC Long Wait Cases Project, Working Group Meeting #2 – Access to Care Program, August 2010 (presentation)
- From Hospital to Home: The Transitioning of Alternate Level of Care and Long-Stay Mental Health Clients – Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health
 - Presentation, March 2011
 - Report, September 2009
- Analysis in Brief: Alternate Level of Care in Canada – Canadian Institute for Health Information, January 2009
- Appropriate Level of Care: A Patient Flow, System Integration, Capacity Solution – Provincial Expert Panel on Alternate Level of Care, 2006

Older People with Challenging Behaviours

- Ontario Behavioural Support Systems: A Framework for Care – Within Our Reach: Solutions for Improving Support for Older Ontarians with Challenging Behaviours – The Ontario Behavioural Support Systems Project (Alzheimer Society of Ontario; Alzheimer Knowledge Exchange; Local Health Integration Networks; supported by the Ontario Ministry of Health and Long-Term Care)
 - Report, January 2011
 - Presentation to the LHIN CEOs/MMC, February 2011

People with a Dual Diagnosis

- Dual Diagnosis: A National Study of Psychiatric Hospitalization Patterns of People with Developmental Disability – Yona Lunskey, PhD, CPsych; Rob Balogh, PhD, The Canadian Journal of Psychiatry, Vol 55, No 11, November 2010

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- Dual Diagnosis: Collaborating for Solutions: Forum Summary – Jenny Carver & Associates, June 2010
- Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis – Ministry of Health and Long-Term Care and Ministry of Community and Social Services, December 2008
- LTC Residents with Developmental Disabilities – Long-Term Care Homes Branch, Community Homes Division, Ministry of Health and Long-Term Care, March 2007 (presentation)

System Initiatives (various documents describing each initiative)

- Integrated Care for Complex Populations (ICCP)
- Home First
- Virtual Ward
- CCAC ICM model
- Aging-at-Home initiatives

Task Forces and Proceedings

- Value & Affordability Task Force (work done on determining how people could be supported to avoid having to come to the ED and designation of ALC once in hospital)
- Networks of Specialized Care Session on how the system can better support/manage people with very high needs (March 25, 2011)
- Seniors and MHA Think Tank (April 4, 2011)
- MOHLTC Provincial ALC Task Force (under the leadership of Dr. Walker)

APPENDIX H: List of People and Networks Consulted During the Preparation of this Report

Hospitals

- Gabriella (Gaby) Golea, Administrative Director, Geriatric Mental Health Program, Centre for Addiction and Mental Health
- Susan Morris, Clinical Director, Dual Diagnosis Program, Centre for Addiction and Mental Health
- Dr. Benoit Mulsant, Physician-in-Chief, Clinical Director, Geriatric Mental Health Program, Centre for Addiction and Mental Health
- Efrem Rone, Social Worker, Geriatric Mental Health Program, Centre for Addiction and Mental Health
- John Trainor, Director, Community Support and Research Unit (CSRU), Centre for Addiction and Mental Health

Long-Term Care Sector

- Dionne Williams, Manager, Client Services, Toronto Central CCAC

Mental Health and Addictions providers

- Mental Health and Addictions Sector Table

Developmental Services Sector

- Dunja Monaghan, Acting Executive Director, Vita Community Living Services of Toronto
- Toronto Network of Specialized Care

Other ALC initiatives

- Heather Brian and Margaret Duffy, Consultants, Healthquest Consulting, CCC/Rehab ALC Project
- Mark Robson, Director, Special Projects, St. Michael's Hospital, Discharge Planning ALC Project
- Dr. David Walker, Provincial ALC Lead and the Provincial ALC Team

APPENDIX I: Service Category and Sub-Category Descriptions

No.	Service category	Description
1.	Information and referral	Information and referral services are provided over the telephone or in person. This is a very low barrier to entry service and typically, no demographic data is recorded about callers or people who request information and referrals in person.
2.	Crisis services a. Crisis telephone services b. Mobile crisis services c. Emergency Department services d. Short-term residential services (i.e., “safe beds”) e. Abuse services	<p>Crisis services offer active treatment and support as soon as possible after an individual has been identified as being in acute distress. Crisis services respond to urgent medical and/or individual psychological needs of people with serious mental illness. Crisis services for seniors provide responses 24/7 to clients who are in a crisis situation and require immediate attention, by assessing their needs and providing short-term intervention. These crisis services may also include linking clients to: community support services (e.g., meals on wheels, day program, friendly visits, etc.); and/or, ongoing specialized psychogeriatric services.</p> <p>Crisis telephone services include assessment and planning, crisis support/counselling, and review/follow-up referral.</p> <p>Mobile crisis services are provided where the client is, and can include includes assessment and planning, crisis support/counselling, medical intervention, environmental interventions and crisis stabilization, and review/follow-up referral.</p> <p>Emergency Department services specialize in the acute care of patients who present without prior appointment, either by their own means or by ambulance. The Emergency Department is usually found in a hospital or other primary care center and operate 24 hours per day, 7 days per week. Due to the unplanned nature of patient attendance, the Emergency Department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention.</p> <p>Short-term residential services provide time-limited emergency housing with high-intensity care for individuals with serious mental illness. This includes services such as assessment, monitoring, care/treatment, symptom stabilization, assistance with securing access to case management and long-term housing services.</p> <p>Abuse services provide counselling and treatment services and support to persons who have experienced an abusive act or who are in an abusive situation, and includes family violence, child witness and transitional support services.</p>

No.	Service category	Description
3.	Primary care	<p>Primary care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.</p> <p>The term 'primary care' is often used synonymously with "general or family practice". While general/family practice is a key element, it is broader than general/family practice alone. It encompasses a wide range of health and personal social services delivered by a variety of professions. Primary care providers can make a significant difference not just in treating illness, but also in supporting people to care for themselves and their families, improving wellness, preventing illness and supporting those with long-term problems, from a health and social well-being perspective.</p> <p>Primary care includes the range of services that are currently provided by general/family practitioners, family health teams, public health nurses, general nurses, social workers, practice nurses, midwives, community mental health nurses, dieticians, dentists, community welfare officers, physiotherapists, occupational therapists, home helps, health care assistants, speech and language therapists, chiropractors, community pharmacists, psychologists and others.</p>
4.	Initial assessment and treatment planning (addictions)	<p>Initial assessment is a process involving mutual investigation or exploration that provides the clinician with more detailed information for the purpose of determining specific client needs, goals, characteristics, problems and/or stage of change. Assessments vary in length according to the client's situation, and comprehensive assessments may be reserved for clients with more complicated histories and problems. This assessment forms the basis for initial treatment planning, a process of negotiation based on feedback from the assessment results, the client's strengths, prioritized problem areas, clinician judgment, client preferences and readiness for change, and the identification of potential barriers to treatment entry. This culminates in the development of a clear plan of action, including referrals as appropriate.</p>
5.	Counselling and treatment services (mental health)	<p>These services provide counselling, psychotherapy and other treatment services to individuals with serious mental illness in the community, including tele-psychiatry.</p>

No.	Service category	Description
6.	Community treatment (addictions)	Community treatment services provide one to two-hour sessions in group or individual format, typically once a week or less often, while the client resides elsewhere in the community. Community counselling/treatment includes brief intervention, lifestyle and personal counselling to assist the individual to develop skills to manage substance abuse/gambling and related problems, and/or maintain and enhance treatment goals. Such activities as relapse prevention, Guided Self-change, family intervention, follow-up and aftercare are included here. Care may be provided with or without medical/psychiatric treatment. The frequency and length of sessions may vary depending on client need and program format. Services may be offered in a variety of settings including outreach to the client's home, school, an addiction agency or other service setting.
7.	Intensive case management a. Mental health b. Addictions c. Dual diagnosis d. Seniors with complex needs	<p>Mental health case management provides at a minimum the following functions: individualized assessment and planning; service co-ordination (linking service recipients with services and supports); supportive counseling; monitoring and evaluation of services provided to recipients; systems advocacy/resource co-ordination; and includes Community Treatment Order (CTO) co-ordination. Mental health case management does not provide clinical counselling, psychotherapy or other clinical treatment interventions.</p> <p>Addictions case management is a process which includes the designation of a primary worker whose responsibilities include the ongoing assessment of the client and his/her problems, ongoing adjustment of the treatment plan, linking to/coordination of required services, monitoring/support, developing and implementing the discharge plan, and advocating for the client. Case management services are offered regardless where the individual is in the addictions treatment system.</p> <p>Dual diagnosis case management provides service coordination, planning and support, monitoring, advocacy and resource coordination to individuals with a developmental disability and mental health needs.</p> <p>Case management for seniors with complex needs is a comprehensive, complex, intensive and frequent service that involves building a trusting relationship with the client/family/network to provide on-going support to help the client function in the least restrictive, most natural environment to achieve an improved quality of life. The specialized mental health and addictions case manager for seniors maintains involvement as client needs change and has a direct link with specialized psychogeriatric, addiction, and community support services. Specific functions may include, but are not limited to: assessment, planning and goal setting; direct service provision/intervention; monitoring and follow-up; liaison, advocacy, consultation; linking to other resources based on the client's needs; collaboration with community agencies; and support for clients and their families/caregivers.</p>

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No.	Service category	Description
8.	Assertive community treatment	Assertive community treatment is provided by multi-disciplinary clinical teams that provide treatment, rehabilitation and support services to clients with severe and persistent mental illness. They provide assertive outreach, individualised treatment, ongoing and continuous services, linkages to services and include a monitoring/evaluation component.
9.	Early intervention in psychosis services	Early intervention in psychosis services provide specialized treatment and support services for individuals experiencing a first psychotic episode, including the provision of support services to their families and/or significant others.
10.	Diversion and court support services	Court support services are provided in the courts to assist individuals and their families with the legal process, link to services and to assist the judiciary. Diversion services are provided pre- or post-charge to link individuals to community or hospital-based mental health services.
11.	Day hospital/treatment services (MH)	Day hospital or day treatment services provide treatment, counselling, rehabilitative/social and recreational services. These services are provided to recipients who to attend for on average between three to twelve hours per day.
12.	Community withdrawal management (addictions)	<p>Community withdrawal management services provide assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. Clients may be simultaneously accessing residential support services, or they may be residing in their home, the home of a significant other or in another community setting, supervised or unsupervised. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided.</p> <p>Level I: Client symptoms can be safely monitored by staff who are not medically trained; the intensity/severity of symptoms can be managed with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department; the client/staff ratios do not permit high intensity symptom monitoring; in consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication: medications for medical problems; medications for diagnosed psychiatric problems; and pain medications only for acute injuries or recent surgery.</p> <p>Level II: Client symptoms can be safely monitored by staff members who are not medically trained; the intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department; routine medical consultation and sufficient staff resources are available to consider management of the following medications/situations: all medications as listed in Level I; clients on methadone; and clients being tapered from benzodiazepines or narcotics.</p> <p>Level III: Client symptoms require monitoring by medically trained staff; medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations: all medications as listed in Level I; circumstances as listed in Level II; and medically-assisted withdrawal.</p>

No.	Service category	Description
13.	Community day/evening treatment (addictions)	Community day/evening treatment services provide a structured, scheduled program of treatment activities typically provided five days or evenings per week (e.g., three to four hours per day) while the client resides at home or in another setting, including residential supportive treatment services, to assist the individual to develop skills to manage substance abuse/gambling and related problem.
14.	Community medical/psychiatric treatment (concurrent disorders)	Community medical/psychiatric treatment is a specific non-residential service to meet the needs of individuals with concurrent disorders. This service may be offered either through a structured day/evening program or community treatment. These services are usually part of broader hospital services and employ physicians, nurses and staff specializing in the treatment of concurrent disorders.
15.	Schedule 1 outpatient services (mental health)	<p>Schedule 1 outpatient services are services that are provided by hospitals to people who are living in the community and do not require overnight stays to receive these services. Mental health outpatient services are typically provided by physicians and/or multidisciplinary teams comprised of clinical social workers, licensed mental health counselors, psychologists, clinical nurse specialists and psychiatrists. Example services include comprehensive psychiatric evaluation; crisis intervention; individual and family psychotherapy; psychopharmacological consultation; medication management; and neuropsychological evaluation</p> <p>Specialized outpatient services for seniors with mental health and addiction issues are usually provided by an interprofessional team with specialized training and skills. This team provides community psychogeriatric and/or addiction services to clients and their families/network in an outpatient clinic – services may include, but are not limited to: assessment; consultation; treatment; case management; education; client advocacy; and linking clients to other services.</p>
16.	Psychogeriatric outreach services a. Geriatric mental health outreach teams (GMHOT) to LTCHs b. Community psychogeriatric outreach teams (CPOT) c. Psychogeriatric resource consultants (PRC)	<p>Psychogeriatric outreach services for seniors with mental health and addictions needs are usually provided by an interprofessional team with specialized training and skills. This team provides community psychogeriatric and/or addiction services to clients living at home in the community, and to their families/network. Such client in-home services may include, but are not limited to: assessment; consultation; treatment; case management; education; client advocacy; and linking clients to other services. Geriatric mental health outreach teams provide these services to people residing in Long-Term Care Homes; community psychogeriatric outreach teams provide these services to people living in other community settings and homes; and psychogeriatric resource consultants provide consultative support to local Long-Term Care facilities and community support agencies, enhance local knowledge and skills, inform the community about existing linkages and support the development of other linkages; provide education and training; assist and advise staff in the development of care plans and interventions for persons with behavioural issues including the use of assessment tools and develop an ongoing relationship with the LTC and community systems</p>

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No.	Service category	Description
17.	Addictions community outreach services a. Adult b. Seniors	Addictions community outreach services provide outreach to the client's home, school, an addiction agency or other service setting. Outreach includes activities such as early intervention but not prevention, education or public relations activities.
18.	Residential withdrawal management a. Level I b. Level II c. Level III	<p>Residential withdrawal management services provide assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. This care is provided in a Withdrawal Management (i.e., detox) Centre, or on an inpatient basis in a hospital. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Service is provided at three levels.</p> <p>Level I: Client symptoms can be safely monitored by staff who are not medically trained.; the intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department; client/staff ratios do not permit high intensity symptom monitoring; in consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication: medications for medical problems; medications for diagnosed psychiatric problems; and pain medications only for acute injuries or recent surgery.</p> <p>Level II: Client symptoms can be safely monitored by staff members who are not medically trained; the intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department; routine medical consultation and sufficient staff resources are available to consider management of the following medications/situations: all medications as listed in Level I; clients on methadone; and clients being tapered from benzodiazepines or narcotics.</p> <p>Level III: Client symptoms require monitoring by medically trained staff; medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations: all medications as listed in Level I; circumstances as listed in Level II; and medically-assisted withdrawal.</p>
19.	Residential treatment (addictions)	Residential treatment provides a structured, scheduled program of treatment and/or rehabilitation activities while the client resides in-house, to assist clients to develop and practice the skills to manage substance use and related problems. In addition to the scheduled program activities, clients have 24-hour access to support and the residential treatment milieu.
20.	Residential/psychiatric treatment (concurrent disorders)	Residential/psychiatric treatment provides a structured, scheduled program of addictions treatment and/or rehabilitation activities provided for clients whose biomedical, emotional and/or behavioural problems are severe enough to require individualized medical/ psychiatric care, while the client resides in-house. The treatment and/or rehabilitation is intended to assist the individual in stabilizing and managing his/her medical/ psychiatric problems, while also addressing the addiction problem per se, or to allow for referral to appropriate substance abuse/gambling treatment. In addition to the scheduled program of addictions treatment and rehabilitation activities clients have 24-hour access to support and the residential treatment milieu.

No.	Service category	Description
21.	Schedule 1 inpatient services (mental health)	Schedule 1 inpatient services are the assessment and treatment services provided by both acute and designated psychiatric hospital inpatient programs.
22.	Psychosocial rehabilitation and community support services a. Educational/vocational services b. Social/recreational services c. Clubhouses d. Peer support and consumer/survivor initiatives	<p>Psychosocial rehabilitation and community support services provide and promote opportunities for seriously mentally ill service recipients to develop inter-personal, social, and leadership skills, in order to interact fully in their communities as defined by themselves. Due to the high co-relation of social development with the determinants of health, it is common to provide psychosocial rehabilitation and support to clients in the areas of a safe place to live, the ways and means to contribute to the community, and the development/maintenance of positive relationships with self/family/friends. Social rehabilitation/recreation requires any or all of the following service recipient-directed services: assessment, counselling, planning, consultation with other service providers, service co-ordination, advocacy, monitoring and evaluation. Also, services include development of linkages with other service providers to maximize opportunities for social rehabilitation to isolated persons. Advocacy to bring about systemic change is an essential element of social rehabilitation.</p> <p>Educational/vocational services provide of a range of employment and education supports including job development/creation; employer outreach; skills development/training; skills training on the job; job search skills; job placement; employment planning/career counseling; supported education; supports to sustaining education/employment; and leadership training. Alternative businesses are consumer-operated businesses that offer full- or part-time employment at market rate or higher. They offer a combination of job development, job placement and supported education within the self-help context. They may also offer self-employment opportunities for consumers to earn income through independent contract work. Support and accommodation are provided on-site to consumer employees.</p> <p>Social/recreational services provide opportunities to develop interpersonal, social and leadership skills, in order to interact fully in their communities as defined by themselves, including assessment, counselling, planning, consultation with other service providers, coordination, advocacy, monitoring and evaluation.</p> <p>Clubhouses provide multi-service psychosocial rehabilitation based on the psychosocial rehabilitation principles, which includes assistance to further vocational and educational goals, secure housing and engage in social and recreational programs. Services for clients or members are recovery focused and include the following: community support/generic case-management services; a structured work day with activities that support recovery; supported education and supported employment, including transitional employment; social and recreational programs; and assistance to client to secure housing.</p> <p>Peer support and consumer/survivor initiatives provide a range of consumer-directed initiatives including self-help, peer support and drop-in centres based on the needs and interest of consumer/survivors in local areas.</p>

No.	Service category	Description
23.	Specialized community supports (dual diagnosis) a. Behavioural assessment and counselling services b. Speech and language therapy c. Clinical support services d. Community outreach services (for caregivers) e. Urgent support services	Specialized community supports include services such as behavioural assessment and counselling services, speech and language therapy; specialized training for professionals who work with individuals who have a dual diagnosis (e.g., psychiatrists, psychologists, social workers and behaviour therapists); services that provide urgent support for individuals whose needs exceed the capacity of their caregivers; community outreach such as training, consultation and counselling for caregivers (e.g., agency staff, family, community health professionals); residential arrangements where individuals receive transitional or ongoing clinical supports from specialized professionals; research, professional development and training in best practice models of care, support and interventions.
24.	Community support services (seniors) a. Intervention and assistance services / non-intensive case management b. Support and counseling c. Adult day programs d. Recreational programs e. Meals on Wheels/ congregate dining f. Friendly visiting g. Transportation h. Volunteer services i. Caregiver support services j. Respite services k. Peer support services l. Home support services	Community support services for seniors include a range of services that help seniors live as independently and interactively as possible in the community. Services include: Intervention and assistance services / non-intensive case management: Support and assistance for a senior in a crisis situation, including planning and coordinating other services. Support and counselling: Provision of support and counselling services to seniors. Adult day programs: supervised and supported social and recreational activities for seniors at locations outside of their homes Recreational programs: Social and recreational activities for a range of seniors from those who are very healthy, to those needing many supports to remain living independently. Activities may include exercise programs, wellness programs, games, cultural events, outings and/or crafts. Meals on Wheels / congregate dining: Nutritious meals delivered to seniors at their home (independent or congregate settings). Meals are delivered by volunteers or staff who provide seniors with regular social contact and check on their safety. Friendly visiting: Regular visits from a trained volunteer to a senior in their home, to provide companionship and social support. Transportation: Rides for seniors who are unable to use public transportation and are not eligible for Wheel Trans or other transport programs. Rides are provided to medical or therapy appointments, shopping and various social activities and programs. Transportation is provided by staff or volunteers. Volunteer services: Provides a range of support services through volunteers including homemaking, light housekeeping, shopping, laundry, personal support, security checks etc.

No.	Service category	Description
	Community support services (seniors) (cont'd)	<p>Caregiver support services: Support provided to individuals and/or family members who are providing care and support for a senior. May include advice and counselling, provided through home visits, visits in the community or in a professional's office.</p> <p>Respite services: Support services for seniors, to temporarily relieve their caregivers. May include adult day programs, personal care, hospice care, monitoring medications or social interaction.</p> <p>Peer support services: Provide a range of self-help, peer support and drop-in services based on the needs and interest of seniors in local areas.</p> <p>Home support services: Services that assist a senior at home with routine or household activities including light housekeeping, laundry and light meal preparation. May include assistance with banking, shopping and errands, or shopping on the senior's behalf. Repairs and maintenance to a senior's home, performed regularly, occasionally, or just once.</p>
25.	Family support services a. Counselling and support services (individual, group) b. Peer support services	<p>Family support services – counselling and support services – include the provision of counselling, support services and training to strengthen and maximize natural supports and existing community networking systems that are relevant to the consumer/family. Family groups may participate in planning and evaluation of care delivery.</p> <p>Family support services – peer support services – include the provision of a range of family-directed initiatives including self-help and peer support based on the needs and interest of consumer/survivors in local areas.</p>
26.	Residential supportive treatment (addictions) a. Level I b. Level II	<p>Residential supportive treatment is provided at two levels:</p> <p>Level I – Housing and related recovery/support services such as lifestyle counselling, coaching for activities of daily living, community reintegration, vocational counselling and mutual aid, provided to clients who require a stable, supportive environment prior to, during, or following treatment, which is accessed elsewhere.</p> <p>Level II – Housing/accommodation in alcohol/drug-free setting. Addiction services are not offered on-site or as part of the housing service.</p>

No.	Service category	Description
27.	Supportive housing (mental health) a. Low-support b. Medium-support c. High-support (transitional and long-term)	<p>Supportive housing (or supports within housing) provides services provided to individuals with serious mental illness for accessing and maintaining housing. These individuals require varying levels of support (e.g., low-, medium- and high-support). Services may include:</p> <ul style="list-style-type: none"> • Up to 24-hour support to mental health service recipients and their significant others to ensure a stable housing environment • Individualized assessment and planning, hands-on assistance with activities of daily living, coordination and support, crisis management, facilitating peer and group support and resident input to their housing environment • Support services provided to individuals who are homeless, or at a risk of being homeless, are included in this functional centre <p>Supportive housing may also include services such as connecting with landlords, matching people to housing, housing advocacy, and teaching life skills</p> <p>Mental Health - Housing Bricks & Mortar pertains to the Ministry-managed funding for provincial and federal buildings provided for mental health services. Organizations receive designated operating funding for building maintenance, utilities, mortgages, property taxes and capital/replacement reserve funds for major repairs to a building, etc.</p> <p>Mental Health - Rent Supplement Program pertains to Ministry-managed funding under the rent supplement program to house clients in privately owned buildings through either head lease or referral agreements.</p>
28.	Residential supports (dual diagnosis) a. Supported independent living b. Group home living c. Family home arrangements d. Individual residential model settings e. Respite services and supports (through Special Services at Home)	<p>Provision of housing supports to assist individuals to live independently in the community. Programs offered are Supported Independent Living, Group Home living situations, Family Home arrangements, and Individual Residential Model options.</p>

No.	Service category	Description
29.	Residential settings (seniors) a. Retirement Homes b. Long-Term Care Homes (LTCHs) i. Behavioural support staff (PIECES) ii. Special care/ behavioural units	Residential settings include: <ul style="list-style-type: none">• Retirement homes: home environments that enable people to maintain their independence and provide light assistance with services such as meals, laundry and housekeeping.• Long-Term Care Homes: provide a wide range of services for people who can no longer live independently. These include: nursing and personal care; regular and emergency medical care by the on-call physician; treatment and medication administration; assistance with activities of daily living; 24-hour supervision; room and board, including laundry services (special diets are also accommodated); pastoral services; and social and recreational programs. Some Long-Term Care Homes have special care/behavioural units that are staffed by people trained in the provision of care and support to people with complex, challenging behaviours. Other Long-Term Care Homes have staff who are specially trained in these areas.
30.	Specialized inpatient services a. Mental health b. Concurrent disorders c. Dual diagnosis d. Psychogeriatric	Specialized inpatient services are the assessment and treatment services provided by both acute and designated psychiatric hospital inpatient programs for specific populations including: people with complex serious mental illnesses for whom treatment in regular inpatient settings has not been effective; severe concurrent disorders (mental health and addictions problems), dual diagnosis (mental health and developmental disability) and seniors with complex mental health needs.
31.	Forensic services	Forensic services serve adults who come into conflict with the law and that may have a psychiatric disorder. Forensic inpatient services: fulfill legal requirements for Court ordered assessments of individuals with possible psychiatric disorders who are referred by the criminal justice system; assess, treat and rehabilitate clients with psychiatric disorders who have been charged with a criminal offence and/or are under the jurisdiction of the Ontario Review Board; make recommendations to the criminal justice system based on the client's history, clinical progress and current mental status; assist clients to achieve their optimal level of biopsychosocial functioning for eventual community re-integration; and where appropriate, arrange adequate community follow-up and after care based on individual needs for designated forensic clients.
32.	Palliative and end-of-life care	Palliative and end-of-life services provides a combination of therapies, such as nursing and social work, delivered by a multidisciplinary team, intended to comfort and support individuals and families who are living with or dying from a progressive life-threatening illness.

APPENDIX J: ALC Risk Triggers Checklists

ALC risk checklist – General (DRAFT)

Please use this checklist to determine whether or not refer the patient to the Toronto CCAC ALC Complex Transitions Team.

i) Patient has been assessed for and does not meet the criteria for Home First – s/he is unable to return home or to pre-hospitalization destination)

OR

ii) Patient has an application for/is appropriate for Complex Care

AND

iii) Patient meets one or more of the following criteria³¹ (check) - the patient:

- Does not have OHIP coverage
- Has an acquired brain injury
- Has significant unmanaged behavioural issues
- Is on a ventilator
- Has a dual diagnosis (mental health and developmental disability)
- Client and family are unwilling to participate in discharge planning after several failed attempts
- Has stage 2 or > wound(s)
- Is a bariatric patient requiring specialized bariatric support
- Has multiple complex medical care needs requiring treatment at a high frequency and time specific multiple timeframes (e.g., tube feeds, suctioning, turning)

³¹ Issues currently under consideration: ways to narrow criteria “acquired brain injury” and “stage 2 wounds” as not all patients that meet these criteria are complex to discharge; adding additional criteria such as “no fixed address.” It is important to note that the purpose of this first screen is to be more rather than less inclusive so as to avoid missing people who should be supported by this team. The team will conduct further assessment to determine the nature and level of involvement of the team in the person’s transition and discharge planning process.

ALC risk checklist – Behavioural Issues-Specific (DRAFT)

Please use this checklist to determine whether or the patient has significant unmanaged behavioural issues.

The patient should be considered as having significant unmanaged behavioural issues³² if the patient meets one or more of the following criteria (check):

- Self-injurious behaviours
- Fire-setting
- Chronic impulsivity, unpredictability and demonstration of lack of judgment
- Frequent, serious inappropriate sexual behaviours
- Severe aggression including threatening verbal outbursts
- Frequent wandering and exit-seeking
- Active substance abuse
- Ongoing verbal outbursts (e.g., continuous calling out)
- Unsafe smoking

³² Issues currently under consideration: whether there are other behaviours to be included and how to describe them (e.g., those associated with long-term institutionalization which have significantly reduced the person's ability to adapt to life in the community; those associated with other symptoms that may not be managed with current treatments or because of lack of adherence to treatment plans). It is important to note that the purpose of this second screen is focus on identification of an individual's functionality and behaviours rather than on the person's diagnosis, the latter of which may not indicate anything about the complexity of the person's situation and his/her level of need.

APPENDIX K: A Rationale for a High-Support 24-Hour Setting³³

In a study of the clinical profile and service needs of adults with a dual diagnosis receiving inpatient and outpatient services from Ontario Psychiatric Hospitals, one in eight patients were identified as having both mental retardation and psychiatric disorder (Lunsky et al, 2006). The recommended level of community care for these patients was found to be higher than for other patients. Only 5 % required tertiary inpatient care. Twenty-seven percent required a high support 24-hour residential community based environment that incorporates a strong clinical and rehabilitation component.

Characteristics:

This level of community care is appropriate for persons whose behaviours make it difficult for them to live independently due to aggression, elopement, and other issues. Depending on client need more secure measures are required. The components can include (adapted from Butterill et al, 2009):

- Individual bedrooms, more than 1 bathroom
- Large common area(s) and/or 'safe area' where clients can be watched by staff, with staff and other clients out of harm's way if necessary (i.e., "reverse confinement")
- Additional safety measures as determined by client need (e.g., video surveillance, keys for the bedrooms and external door and window alarms or buzzers, two-way radios, cell phones and on-call emergency systems). Items which could be used as weapons are bolted to walls and windows are covered in lexan. Some rooms may have padding to keep individuals prone to self-injury safe.
- Large fenced-in yard if not in the country
- Capacity for safe transport of clients for appointments and to community leisure activities as travel by TTC may not be safe
- Higher staff ratios (including "awake overnight" staffing) that can be flexed when necessary – as high as 1:1
- Weekly clinical meetings to review and troubleshoot issues

³³ This document was developed by Susan Morris, Clinical Director, Dual Diagnosis Program, Centre for Addiction and Mental Health, and Chair of the Toronto Network for Specialized Care

Currently there are approximately 12 beds available within the Toronto Network of Specialized Care that fit this description, providing *transitional* (2-4 years) length of stay. Long-term housing supports available to the system with this level of care is even more limited and usually has been designed for specific populations such as offenders or those with severe autism.

Clinical support model:

Successful transition from hospital to community and successful long-term community tenure requires a pre-planned appropriately paced approach to establish the required level of intensive supports, allow for the coming together of the ‘primary team’ (including client, family, health, mental health and developmental service providers) and establishment of a realistic safety net with the role of the Emergency Department and criteria for re-hospitalization articulated within a community-based crisis support and management plan. This requires clear identification of responsibilities and accountabilities between the hospital mental health and/or specialist provider and the community mental health/developmental services provider(s). A key component in the process and through the lifespan of the person’s treatment and care is the identification of a ‘fixed point of responsibility to drive the process and build trust between the members’ of the primary team” (Butterill et al, 2009).

Experience with the Toronto system has found that clinical supports that are more embedded within the housing program are more effective programmatically for the client and team. This enables quicker inter-professional responses to daily changing needs of the client. It also provides more immediate support to staff to prevent risk situations and burnout. There currently exist models where through inter-agency protocols and agreements, a transitional treatment bed has access to specialized clinical supports. These arrangements can only go so far as in the end they deplete the resources of the contributing service to be available for other community needs, and they can lead to fragmentation of treatment, rehabilitation and accountability.

The following table provides an *example* of what an in-house clinical team could look like, augmented by ‘consultation’ services that currently exist in the system – thus making the most effective use of all available skills. There can be many variations on this example in-house clinical team composition.

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In-House Clinical Team	External Consultation
<p>Nursing</p> <ul style="list-style-type: none"> - Medical/metabolic monitoring - Supervision of regulated acts - Liaison with family practice 	<p>Family Practice</p> <ul style="list-style-type: none"> - Able to provide weekly or monthly follow-up when necessary - Comfortable with population and the team approach – particularly working with SDMs and receiving information from a variety of disciplines - Flexible appointment times and large waiting room to accommodate behaviours - Note – Practice models such as CHCs or FHTs maybe the best fit
<p>Behaviour Therapy</p> <ul style="list-style-type: none"> - Development of positive behavioural support programs - More intrusive programs can be developed with the approval an agency oversight committee and as necessary MCSS - Staff training to support consistent implementation and data collection of behaviour programs (e.g., through staff and program changes) - Monitoring of outcomes weekly and monthly 	<p>CCAC</p> <ul style="list-style-type: none"> - Blood work - Access to “one-off” treatments – assumes knowledge and skills to adapt standard practices to the needs of this population
<p>Psychiatry Consultation³⁴</p> <ul style="list-style-type: none"> - Specialized expertise in field - Prescribes psychiatric medication - Liaison with Family Physician 	<p>Psychiatry</p> <ul style="list-style-type: none"> - Specialized expertise in field - Timely access for Family Physician - Ongoing monitoring quarterly or monthly depending on fluctuations - In-home appointments when necessary

³⁴ In-house psychiatry consultation is ideal but not easily accessible. Psychiatry consultation from specialists to Family Physicians is generally the current model (as with all mental health services) – however accessibility is also an issue here (i.e., in relation to the number of specialist psychiatrist available in Toronto and their capacity to respond as needed). Some psychiatric consultation is available through General Hospital outpatient services but these services are clinic-based due to current funding structures and models.

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In-House Clinical Team	External Consultation
<p>Other: as determined by the person’s profile</p> <ul style="list-style-type: none"> - Psychology - Occupational Therapy - Nutritionist - Speech and Language - Art therapy - Music therapy 	<p>Other: as determined by the person’s profile</p> <ul style="list-style-type: none"> - Dental - Neurology - Optometry - Ophthalmology, etc - Community mental health services – rehabilitation, club house
<p>In this model – weekly inter-professional clinical meetings occur to stay on top of changes needs in the person’s environment medical, emotional or psychiatric status</p>	<p>Consultants will need to be reimbursed when required to attend team meetings if not part of their current payment formula(s)</p>

It is important to weigh the risks and benefits of continued hospitalization versus provision of supports through community high support environments. In reviewing the literature, Butterill et al reported that for many individuals with a dual diagnosis, long-term institutionalization has left them with minimal community skills and a behavioural repertoire that has been adapted to a hospital environment (2009). Of note in their review are the following findings:

- Increased time taken for discharge planning tends to result in more appropriate discharges and greater success rates than when placements are under-supported or “out of region”
- A reduction in aggressive and challenging behaviours among 80% of residents who were discharged from a long-stay specialized dual diagnosis hospital program at six-month and one-year follow-ups
- Further improvements with respect to quality of life and satisfaction have been shown when dual diagnosis clients can access specialized care in the community

In summary the evidence to support development the development of pathways and access to community living is no different for individuals with a dual diagnosis than the general population. Costs will be higher, due to the unique and complex nature of each person’s needs, but likely still lower than maintaining the person in a hospital setting. However, the quality of life for the person, as well as for those who live or work with him/her, will be much improved.