

**TORONTO REGION
LONG TERM CARE /
MENTAL HEALTH
FRAMEWORK
REPORT**

DECEMBER 2006

LTC/MH Framework Report

Index

- Executive Summary - page 3
- Introduction And Background - page 9
- A. LTC/MH Psychogeriatric Framework Vision - page 11
- B. LTC/MH Psychogeriatric Framework Mission - page 11
- C. LTC/MH Psychogeriatric Framework Scope - page 11
- D. LTC/MH Identification of Symptoms of Serious Behavioural Response Issues - page 12
- E. Framework Components - page 13
 - 1. Role of the CCAC - page 13
 - 2. LTCHs
 - 2.1 LTCH Responsibilities - page 14
 - 2.2 Internal LTCH Structure and Process - page 15
 - 2.3 LTCH Decision-Making Guidelines- Management of Serious Behavioural Response Issues - page 17
 - 3. Role of Geriatric Mental Health Outreach Teams - page 21
 - 3.1 Alignment of Geriatric Mental Health Outreach Teams and LTCHs - page 22
 - 4. Role of Solo Practitioners - page 22
 - 5. Role of Psychogeriatric Resource Consultant Program - page 23
 - 6. Role of Hospitals - page 23
 - 7. Role of Police - page 26
 - 8. Role of Community Agencies - page 26
 - 9. Linkages - page 27
- G. Ethnocultural Considerations - page 28
- H. Implementation and Sustainability of the LTC/MH Framework - page 29
- I. Evaluation - page 29
- J. Conclusion - page 30

- APPENDIX 1: Steering Committee Terms of Reference and Membership - page 31
- APPENDIX 2: LTC/MH Framework Program Logic Model - page 34
- APPENDIX 3: LTC/MH Framework Consultations - page 35
- APPENDIX 4: Recommendations Beyond the Scope of the Steering Committee - page 40
- APPENDIX 5: Geriatric Mental Health Outreach Teams/Long-Term Care Homes and Community Care Access Centres Alignments - page 41
- APPENDIX 6: 6A Survey Findings; 6B; The Electronic Survey - page 45
- APPENDIX 7: LTC/MH Framework Objectives - page 55
- APPENDIX 8: Identifying Symptoms of Behavioural Response Issues - page 56
- APPENDIX 9: Behavioural Support Staff Functions - page 57
- APPENDIX 10: Goals and Guiding Principles for Geriatric Mental Health Outreach Teams and Long-Term Care Home Alignment - page 58
- APPENDIX 11: Summary of Existing Hospital Specialized Services - page 59
- APPENDIX 12: Toronto Police Contacts - page 64
- APPENDIX 13: Draft Terms of Reference: System 13A; 13B Specialized Care; 13C Waitlist – page 66
- APPENDIX 14: Proposed Patient Flow Through “The System” – page 69
- APPENDIX 15: Working Group Membership – page 70
- APPENDIX 16: Acronyms – page 71

Executive Summary

The Toronto Region Long Term Care/Mental Health (LTC/MH) Steering Committee was initiated by the Toronto Region Office of the Ministry of Health and Long-Term Care in November 2005, to support the Toronto Region Office's Long-Term Care Homes bed strategy, and to respond to the recommendations arising from the Casa Verde inquest report (June 2005). The overarching goal of the LTC/MH Steering Committee was to provide advice and support the development and implementation of a Toronto Region integrated framework of long-term care, hospital, and geriatric mental health outreach services that could support and provide care for individuals living in long-term care homes (LTCHs), or awaiting placement in a LTCH who have serious mental illness with related severe behavioural response issues.

Identified providers to be engaged in the implementation of the Framework included all LTCHs, Community Care Access Centres (CCAC), geriatric mental health outreach teams, hospital emergency rooms and specialized assessment, treatment and behavioural management programs, Psychogeriatric Resource Consultants (PRC) working within the Psychogeriatric Resource Consultants Program (PRCP), and physicians serving seniors with serious mental illness and associated behavioural response issues who:

- reside in Long Term-Care Homes;
- are being assessed by a CCAC for admission to a Long Term Care Home; and/or
- live in the community and are provided services by community agencies.

For the purposes of this cross-sectoral initiative, seniors have been defined as adults 55 years and over, and as such all Framework recommendations apply to this age group.

The Framework is one component of Toronto Region's LTC Homes Bed Strategy that is addressing the need to better serve individuals living in LTCHs who require special programming for significant behavioural response issues or, who are waiting for LTCH placement. The Ministry allocated \$1.67M of Mental Health Accord funding (05/06) to support the development of the Framework.

Based on current best practices, the Framework is intended to provide Toronto LTC/MH system providers with a consistent, coordinated and integrated approach to providing care for seniors with serious mental illness and serious behavioural response issues, setting out a variety of resources that should be available for LTCHs to access and utilize to meet the needs of residents, and their families/substitute decision makers (SDMs). The Steering Committee emphasizes that for the Framework's mandate to be realized, all of the report's recommendations relating to both LTCHs and the other service providers, need to be fully implemented.

Consistent with LTC Facility Program Standards: 802-01, 803-01, 804-01, 903-01, the Framework emphasizes that the LTCH retains responsibility for:

1. managing the care of the resident in the LTCH;
2. monitoring the care status and transitioning the resident to and from a hospital;

3. upon a planned resident discharge from a LTCH, collaborating with the resident and his/her support/substitute decision maker to facilitate referral to appropriate accommodation and services, where possible.

Committee Approaches and Major Activities

- met regularly from November 2005 to April 2006;
- established four working groups with additional hospital and community sector representatives to support the Committee's mandate (refer to Appendix 1 for Terms of Reference (TOR) and appendix 5 for working group membership);
- focused primarily on the LTCHs and related stakeholders per Terms of Reference, and also considered the needs of CCACs, and community agencies serving seniors;
- reviewed relevant LTC Facility Program Standards (802-01, 803-01, 804-01, 903-01) which establishes LTCH responsibility for managing the care of the resident in the LTCH;
- consulted on current best practices with health care providers in other regions of Ontario;
- considered the findings of an electronic survey disseminated to all Toronto LTCHs, CCACs, community support service agencies (CSS), hospital programs, and other providers serving seniors with serious mental illness and severe behavioural issues. (Refer to Appendix 3A for survey findings);
- conducted literature reviews;
- consulted widely with a variety of stakeholders to ensure Framework appropriateness and applicability. (Refer to Appendix 3 for consultation summary.)

Expected outcomes following full implementation of the LTC/MH Framework are:

Short Term (1 - 3 years):

- decrease in the number of "difficult to place" applicants on the LTCH wait lists;
- decrease in the number of assaults by LTCH residents;
- decrease in the number of negative assessment transfers of LTCH residents to Emergency Rooms;
- decrease in the number of requests for Toronto Police Service interventions; and
- increase in LTCH and resident and family/substitute decision maker satisfaction (SDM)¹.

Long Term (3 - 5 years):

- improve the ability of the LTCH/MH system to provide timely and clinically appropriate services for seniors with serious mental health with serious behavioral response issues.

¹ The substitute decision maker is used with the understanding that it applies only in situations when the resident is not capable.

Summary of Recommendations:

It is recommended:

- That LTCHs develop clear roles and responsibilities, as well as internal LTCH structures and processes to facilitate care for seniors with serious mental illness and related behavioral response issues including:
 - implementing a Quality Management Program for identifying, tracking, improving, and ensuring an effective collaborative model of care for residents with serious mental illness and related behavioural responses;
 - implementing coordinated responses for geriatric mental health outreach team visits (e.g. clinic-like approaches with assigned behavioral support staff) to achieve better outcomes and more effective and efficient use of the geriatric mental health outreach team's clinical time;
 - continuing to support access to PIECES training for staff whenever such training is available in recognition of the essential role that PIECES trained staff play in the care of seniors with serious mental illness and behavioral response issues;
 - utilizing the Framework's Decision Tree as appropriate to the emerging situation(s) to assist in determining how to best manage behaviours considered challenging by the homes and the resident's family/SDM, within the resources available to the LTCH and Framework partners.
- That each LTCH consider utilizing existing resources to implement a "behavioral support" staff role whose responsibilities include coordination of the external consultants' consultation (e.g. geriatric mental health outreach team, geriatric psychiatrist, geriatrician) at the home, and follow-up with the resident's unit, the external consultant, and the resident/and his or her family/SDM.
- That LTCHs implement a collaborative model approach to assist LTCH staff and external consultants (e.g. geriatric mental health outreach teams, geriatric psychiatrist, geriatrician) in effective collaboration when two or more external consultants are involved in the assessment and/or treatment of the same resident.
- That LTCHs facilitate the transfer of a resident to a hospital emergency room (ER) by:
 - sending information to the ER similar to that contained on the geriatric mental health outreach team's referral form
 - including the relevant geriatric mental health outreach team's name and phone number with the documentation accompanying the resident
 - notifying the relevant geriatric mental health outreach team when a resident is being transferred for a hospital admission

- That the LTC and hospital ER sectors (including GEM nurses) work collaboratively to develop a PIECES program for hospital ER staff, based on a common understanding of the issues that each sector deals with in the care of seniors with serious mental illness and related behavioural issues.
- That hospital ERs develop coordinated plans for their emergency services to address the needs of individuals with behavioural response issues related to serious mental illness.
- That hospital ERs develop a common referral form/ tool for intake to be used by all referral sources when making referrals/transferring a client/resident to an ER.
- That LTCHs establish working relationships with the Toronto Police Service Division in their neighbourhood, particularly the Community Relations Officer as a community support in dealing with mental health and behavioural response issues.
- That geriatric mental health outreach teams have clear roles and responsibilities, including a potential role in the event of LTCH emergencies, consultation to LTCHs, and facilitating the transfer of seniors with mental illness and behavioral response issues to hospitals, as required, who:
 - have just been accepted for a LTCH admission;
 - are current LTCH residents who require a hospital admission
- That geriatric mental health outreach teams work with LTCHs and the LTCHs' attending physicians to facilitate a resident's direct admission to a hospital and subsequent discharge back to the LTCH as appropriate and possible.
- That geriatric mental health outreach teams work collaboratively to develop a system/mechanism to provide consultation and support for the LTCHs and CCACs assigned in their caseload on a 7 days a week, 8 am – 8 pm basis. The mechanism could include other specialized mental health providers such as CAMH, TRI, Baycrest, and St. Elizabeth Health Service's geriatric mental health crisis team.
- That geriatric mental health outreach teams provide consultation to hospital emergency services and in-patient units to facilitate required transfer of LTCH residents to the most appropriate hospital inpatient service.
- That geriatric mental health outreach teams provide consultation and support to CCACs by:
 - participating on any joint LTC/MH mechanism that may be established to review and make recommendations for seniors on the LTCH wait list identified as "hard to place" due to behavioural issues related to mental illness, and who are waiting in place in the community;
 - participating in the development of care plans for seniors with known serious mental illness and severe behavioural response issues prior to their admission to the LTCH, to facilitate the transition of the senior from his or her current setting (e.g. home, hospital);

- providing consultation for seniors whom the CCAC has identified as having symptoms of a serious mental illness with related behavioural response issues to assist the CCAC to identify appropriate LTCH placement, and/or other services.
- That all service providers in the LTC/MH system be formally aligned through memoranda of agreement that clearly identify roles and responsibilities, referral mechanisms, communication strategies, and conflict resolution strategies.
- That a single centralized information phone line linked to a hospital with specialized geriatric mental health programs be established to provide consultation to community agencies on issues related to seniors with mental illness and related behavioural response issues.
- That PRCs continue to provide and enhance education initiatives to the degree possible, to LTCHs and community agencies serving seniors.
- That information on existing mental health crises services be made available to community agencies.
- That a future Steering Committee be struck to advise and support the development and implementation of a LTC/MH Community Framework to specifically address the needs of seniors living in the community.
- That representatives of the geriatric mental health outreach teams, LTCHs, PRCs and Toronto mental health services with ethnocultural competencies form an advisory group to design a support system for LTCHs, residents and their families/SDMs that facilitates the access of resources to provide ethnoculturally responsive services.
- That the following three committees be established as part of the implementation of the Framework:
 - LTC/MH System Advisory Group: to review and address issues/make recommendations related to the LTC/MH Framework, including ethnocultural considerations to ensure the Framework's on-going sustainability.
 - Specialized Care Advisory Group: to consider issues related to admission of LTCH residents to the specialized inpatient services at CAMH, TRI and Baycrest Centre. This includes development of coordinated access to these specialized services for LTCHs, community, and hospital referrals.
 - Wait List Review Advisory Group to review:
 1. The clinical needs of seniors who have been deemed eligible for placement in a LTCH and are awaiting placement and have severe behavioural issues that may be related to serious mental illness and,
 2. System/policy issues related to LTCH placement (e.g. specialized units, marketing)

- That a process for evaluation and performance indicators be developed to ensure on-going sustainability and relevancy of the Framework's recommendations.

Note: There were a number of other related recommendations that arose during the development of the Framework but were beyond the Committee's mandate. The Committee hopes that these recommendations will be addressed/ implemented in a future appropriate forum. (Refer to Appendix # 4 for related recommendations).

Introduction And Background

The LTC/MH Steering Committee was struck in November 2005 to provide advice and support the development and implementation of a Toronto Region framework of long-term care homes (LTCHs), Community Care Access Centres (CCACs), geriatric mental health outreach teams, specialized inpatient assessment/treatment programs, Psychogeriatric Resource Consultant Program (PRCP), and physicians providing services for seniors with serious mental illness with related behavioural response issues who:

- reside in Long Term-Care Homes,
- are being assessed by a CCAC for admission to a Long Term Care Home and/or
- live in the community and are provided services by community agencies.

In keeping with the Terms of Reference, the primary focus of the Committee's deliberations focused on the LTCH sector which includes the role of CCACs in the LTCH placement process, and related stakeholders.

Although a number of factors were considered in establishing the Steering Committee, two major factors were:

- To respond to the June 2005 Coroner's Jury Report from the Casa Verde Jury Report which included among its 85 recommendations, a recommendation for the development and implementation of a plan or Framework that would ensure "appropriate standards, funding, tracking and accountability for Long Term Care (LTC) and other facilities treating such individuals"; and
- To support Toronto region's LTCH Bed Strategy that is addressing the need to better serve individuals living in LTCHs, or who are waiting for placement in a LTCH. Currently there are a significant number of individuals on the Toronto Region Wait List waiting for LTCH placement that have been assessed as aggressive, resistive, disruptive, alcoholic and/or exit seeking (928 as of Feb 2006). As well, as of December 2005, only 47 of Toronto's 87 LTCHs received some level of coverage from geriatric mental health outreach teams.

The Ministry allocated \$1.67M of Mental Health Accord (05/06) funding to support the development and implementation of the Framework. The funding was allocated as follows:

- \$461,000 to enhance the Behavioural Support Program at Baycrest's Behavioural Neurology Unit. This enhancement provides LTCH priority access to 5 beds of the 20 bed unit for assessment and short term behaviour management for residents 55 years and over with mental illness and related behavioural response issues.
- \$1.2 M for new /enhanced geriatric mental health outreach teams to ensure that all Toronto LTCHs have access to specialized outreach services serving seniors 55 years and over with serious mental illness and related serious behavioural response issues.

To ensure a timely implementation of geriatric mental health outreach services, the Ministry realigned the geriatric mental health outreach teams with LTCHs and CCACs in July 2006 ensuring that each LTCH and CCAC has an established linkage to a mental health outreach team. (Refer to Appendix 5 for the alignments.)

LTC/MH Steering Committee Process

The Steering Committee met regularly from November 2005 to April 2006 to accomplish its mandate. Each meeting included presentations on best practices currently in place in Toronto agencies, and/or in agencies in other jurisdictions in Ontario. Four working groups were struck (which included both Committee and non-Committee members) and given the following tasks:

- 1) Identification of criteria for appropriately recognizing this population.
- 2) Development of the Framework vision, mission, scope, roles and responsibilities, and linkages of stakeholders.
- 3) Identification of existing resources, recommendations for alignment of LTCHs with geriatric mental health outreach teams, and clarification of access criteria and processes for hospitals with specialized geriatric mental health and/or behavioural management programs.
- 4) Identification of LTCH best practices for managing behavioral response issues associated with mental illness that pose a risk to self or others.

The Committee also carefully considered the results of an electronic survey disseminated to Toronto LTCHs, CCACs, and CSS agencies, hospitals, mental health outreach teams; conducted literature reviews; consulted with geriatric mental health outreach providers on best practices in other regions of Ontario.

Survey Findings:

The LTCH response rate to the electronic survey was 86% (73 of 84 LTCHs). Note: survey results represent the percentage of respondents to each question, and not the total number of LTCHs. The four hospitals serving Toronto with specialized programs had a 100% response rate. One acute care hospital responded regarding its general mental health unit.

Identified system issues included:

- a lack of information on residents' mental health status and or existing behavioural response issues that have occurred prior to admission
- increased support is needed from mental health specialists, time, financial and human resources;
- increased education related to mental health issues is needed;
- regular mental health outreach team visits to assess/reassess residents are required;
- need to achieve reduces waiting/response times and faster service when a crisis occurs;
- formal agreements are required between LTCHs and hospitals and mental health outreach teams/psychiatrists;
- significant lack of access to PIECES training;
- even when LTCHs do have PIECES trained staff, there are not enough and/or

- staff turn-over is such that additional trained staff are consistently required;
- a lack of specialized care units for residents who although do not require hospitalization, cannot be safely cared for in the LTCH system.

Consultation on Draft Framework:

On completion of the draft report, the Committee consulted widely with a variety of stakeholders to ensure Framework appropriateness and applicability. There was strong support for the Framework, with recommendations mainly centering on issues related to implementation, including linking with planned and current provincial and local initiatives.

A. LTC/MH Framework Vision

Seniors (defined as individuals 55 years and over for this initiative) with serious mental illness with related behavioural response issues living in long-term care homes, and/or are eligible (awaiting placement, and/or who access services via community agencies) will receive needed, appropriate, ethnoculturally sensitive, care in a timely fashion.

Seniors will have access to services to assist in the early identification and intervention of serious behavioural response issues related to mental illness, as well as with on-going behaviour management support to help avert, and/or facilitate management of crises so that they can remain in their current LTCH, avoid unnecessary transfers between the LTCH and hospital, and achieve effective and safe transfers when transfers are necessary.

B. LTC/MH Framework Mission

The LTC/MH Framework will:

- identify structures and processes that will lead to a consistent, coordinated and integrated system that recognizes the accountability of the LTCH for its residents and supports this care;
- clarify and strengthen relationships between practitioners and organizations that provide care for seniors with serious mental illness and related behavioural response issues.

C. LTC/MH Framework Scope

The LTC/MH Framework applies to:

- All Toronto LTCHs
- Geriatric Mental Health Outreach Teams
- Hospital emergency rooms, specialized assessment, treatment and behaviour management programs, e.g. Centre for Addiction and Mental Health (CAMH), Toronto Rehabilitation Institute (TRI), Baycrest's Behavioural Neurology Unit,)
- CCACs
- Psychogeriatric Resource Consultant Program
- Psychiatrists and/or other specialists providing consultation services within LTCHs
- Physicians providing care within LTCHs

Consistent with the Committee’s terms of reference, the Framework also provided direction to address to the extent possible, the needs of seniors with serious mental illness and related behavioural issues who access services through community agencies.

D. Identification of Symptoms of Serious Behavioral Response Issues

The Steering Committee quickly recognized the need for a common understanding across the LTC/MH system of how serious behavioural responses would be identified to ensure consistency of application of Framework strategies and approaches by all providers. The Working Group assigned to this task identified the following behaviours as being most difficult to cope with:

Psychological symptoms of	Behavioural symptoms of
<ul style="list-style-type: none"> - delusions - hallucinations - depression - sleeplessness - anxiety - suicidal behaviour 	<ul style="list-style-type: none"> - physical aggression - wandering, stalking - restlessness - agitation - sexual disinhibition - pacing - screaming, crying, cursing - substance abuse - apathy

The Working Group also recommended the following criteria be considered when intervention from specialized geriatric mental health services is being considered:

<ul style="list-style-type: none"> - extent of risk of harm to self or others - ability of caregiver to manage the behavior - severity - frequency of occurrence - history of violence - history of mental illness - medical status, ruling out acute medical conditions, e.g. delirium - response to intervention from internal resources (e.g. change of medication, care plan or environment) - response to intervention from PRC

E. Framework Components

The following section defines and/or clarifies roles and responsibilities of the various organizations and practitioners providing a specific service(s) to either LTCH applicants, i.e. CCACs, or to LTCH residents e.g. LTCHs, external consultants such as geriatric mental health outreach teams and geriatric psychiatrists, the PRC, hospitals. The role of the Toronto Police Service is also described. Also included is a brief section on community agencies serving seniors with some suggestions to assist these agencies on accessing existing mental health and crisis services.

The Steering Committee identified:

- a process for CCACs to use to assist seniors in the community who are: a) approved for but still awaiting LTCH admission, and b) applying for LTCH admission and require monitoring and/or some level of mental health/ physical care/ in-home support
- a variety of resources that LTCHs can utilize to meet the needs of both residents, and their families/SDMs, and seniors applying for LTCH admission
- strategies for community agencies serving seniors
- strategies to improve linkages among existing resources

1. Role of the CCAC

CCACs are responsible for:

- determining LTCH eligibility
- ensuring that the information collected in determining an applicant's LTCH eligibility reflects and describes the applicant's existing behavioural response issues that will assist LTCHs in:
 - decision-making re acceptance of an applicant,
 - developing and on-going management plan if the applicant is accepted
- maintaining and up-dating the LTCH wait list
- providing on-going information to the LTCH on the status of applicants with mental illness and related behavioural response issues who are on the LTCH waitlist
- participating with geriatric mental health outreach teams and LTCH staff in a pre-admission review of applicants with known mental illness and related behavioural issues to assist with the applicant's transition to the LTCH
- co-coordinating and participating on the CCAC Advisory Group

Many seniors assessed for LTCH eligibility present with significant challenges relating to serious behavioural issues. Frequently seniors:

- do not have a family physician
- are estranged from, or do not have family/SDM, and
- present as complex and difficult to assess

CCACs identified the following three issues related to their ability to provide services to these seniors:

1. Access to specialized in-home support to conduct an evaluation of the client in his or her own setting
2. Access to psychiatric consultation for the client (it is noted that geriatric mental health outreach teams have limited ability to consult with seniors in the community in the absence of a family physician)
3. Access to client documentation – currently information is not released to the CCAC due to issues related to federal privacy laws (PHIPPA) and sharing of information

To assist CCACs, the following process is recommended:

1. CCAC case manager co-ordinates a medical assessment to eliminate possible physical issues through:
 - a. linkage with family physician
 - b. transfer of the senior to a hospital emergency department (on a Form 1 if appropriate) contacting the GEM nurse in advance (where available), or
 - c. hospital referral
2. In the event that no medical issues are found, the CCAC case manager refers the senior to one of the following providers for consultation and follow-up:
 - a) Inpatient mental health units
 - b) Independent geriatric psychiatrist or geriatrician
 - c) Geriatric mental health outreach team
 - d) COTA Geriatric Mental Health Team
 - e) St. Elizabeth Health Care

Recognizing that the above approaches will not fully address the magnitude of the challenges facing CCACs, the Steering Committee further recommends:

- implementation of a model of care in the community that considers both physical and mental health issues for seniors with serious mental illness with related behavioural response issues, and without a family doctor (similar to the Palliative Care Model)
- legal opinion regarding release of client information to the CCACs

2. LTCHs

2.1 LTCH Responsibilities

The LTCH is responsible for the clinical care of their residents for (LTC Facility Program Standards: 802-01, 803-0, 804-01, 903-01):

1. Managing the care of the resident in the LTCH.
2. Monitoring the care status and transitioning the resident to and from a hospital, and
3. Upon a resident planned discharge from a LTCH, collaborating with the resident and his/her family/SDM to facilitate referral to appropriate accommodation and services, where possible.

LTCHs are responsible for exploring, implementing, and evaluating appropriate treatment options for residents with mental illness with related behavioural responses in collaboration with other practitioners in the mental health system. Appropriate treatment involves full assessment of the mental and physical health status of all residents, and implementation of appropriate urgent and on-going treatment interventions by LTCH staff and supported by external resources, as needed. For LTCH residents with behavioural and mental health issues, LTCH responsibilities include:

- determining which residents require external consultation; effectively utilizing PIECES trained and PRC resources prior to making a referral to external consultants;
- specifying which external consultant is to provide the consultation to avoid confusing or conflicting management plans and treatment recommendations;
- determining priorities for referrals based on urgency of need;
- establishing clear processes for referrals for elective and crises interventions;
- responding to urgent situations using an pre-determined, risk-based approach;
- determining the staff person responsible for coordinating referrals to the external consultant [suggest 1 contact per LTCH or per LTCH floor];
- determining the need for transfer of a resident to a hospital;
- ensuring consultation treatment plans are reviewed and taken into consideration;
- maintaining contact with the hospital to follow the resident's care after transfer;
- notifying the geriatric mental health outreach team or solo practitioner when their patient has been transferred to a hospital for a severe behavioural episode related to a serious mental illness.

2.3 Internal LTCH Structure and Process

The following model is recommended to assist LTCHs to best meet the needs of their residents with mental illness with related behavioural response issues, and to support effective utilization of geriatric mental health outreach teams, geriatric psychiatrists, and other external consultants. The model highlights:

- an evidence based approach (quality management program)
- an interprofessional approach - use of behavioral support staff, PIECES trained staff, programs and services staff, PRCs, geriatric mental health outreach teams
- regular communication within the LTCH and with external consultant supports
- on-going education for LTCH staff

Quality Management Program

- Each LTCH should ensure its Quality Management Program allows the LTCH to identify, track, improve, and maintain a consistent approach for the management of behavioural response issues. Examples of indicators to track include:

Structure Indicators:

- type, frequency and severity of challenging behaviours

Process Indicators:

- High Intensity Needs forms requests submitted and approved
- frequency of use of Form 1 under the Mental Health Act
- number of resident transfers to emergency rooms for mental illness with related behavioural issues

- number of unusual occurrence reports related to behaviours and injuries resulting from behavioural response incidents
- number, day, time, and reason for emergency phone consultation with external consultants

Outcome Indicators:

- # of occurrence reports after regular access to/interventions by a geriatric mental health outreach team/solo practitioner
- # of transfers to hospitals after implementation of the Decision Tree approach

Behavioural Support Staff:

- it is recommended that each LTCH consider utilizing existing resources to create and maintain a behavioral support role to act as the link between the geriatric mental health outreach team, geriatric psychiatrist/other external consultants, and the resident's unit. The responsibilities for this role might include co-ordination of the external consultants' consultation time at the home, and follow-up with the resident's unit, the external consultant and the resident family/SDM.
 - the position may be either a management staff, e.g. Director of Care, and Nurse Manager, or alternatively a clinical staff, e.g. RNs, OTs, SWs who ideally, would be PIECES trained.
 - the number of staff assigned to the behavioural support role should be related to the size of the LTCH, and the number of LTCH residents with mental illness with related behavioural response issues.

Consultation Model with Geriatric Mental Health Outreach Teams

- LTCHs are encouraged to establish a flexible model in consultation with geriatric mental health outreach teams, so that residents for the most part can be seen in a clinic-like setting. Therefore if possible, LTCHs should identify space that can be used for consultations. However when clinical reasons make it necessary, a resident will be seen in his or her own room.
- Each LTCH to develop its own criteria for referral to the geriatric mental health outreach team considering the residents' needs, the risks identified (e.g. the number of unusual occurrences) and the LTCH's Quality Management Program results.
- Clinic frequency should be related to assessed resident needs (suggested benchmark: time per resident: 30 minutes (excluding assessment); 4/5 residents/visit, 200 bed LTCH – 1 day per week)
- Each LTCH should identify staff in the behavioural support role to co-ordinate geriatric mental health outreach team consultations.

Referral:

The LTCH is responsible for identifying residents who require geriatric mental health outreach team consultation; the LTCH attending physician is responsible to make the referral to the geriatric mental health outreach team.

Follow-up On External Consultations

- the external consultants' consultation notes form part of the resident's health record
- progress notes should refer to the external consultants' consultation, and the location of the detailed external consultants' reports in the resident's health record
- the external consultants' recommendations should be reviewed by the care team, ideally at a care team conference with the family/SDM
- the LTCH, in consultation with the family/SDM, determines whether or not to implement the external consultant's recommendations
- the LTCH, in consultation with the family/SDM, incorporates the agreed upon geriatric mental health outreach team's/ external consultant's recommendations into the resident's care plan (Section B4, 2.4 5.3), ensuring staff on all shifts are informed of changes to the care plan
- the LTCH ensures the resident's family/SDM is contacted to obtain consent as needed, and is informed of on-going external consultant's recommendations
- Staff assigned to the behavioural support role maintain contact with the external consultant regarding the status and/or impact of their recommendations

Education for LTCH Staff

- the LTCH should provide and/or arrange for staff training for all staff specific to the needs of residents with mental health with related behavioural issues
- the LTCH should take steps to have as many staff trained in PIECES as is possible based on course availability and/or other formal educational programs about dementia care
- the LTCH should request that the PRCs be involved on an ongoing basis to provide topic-specific and/or case based education support to teams or individual care-givers, and assist to transfer knowledge to practice following a consultation or an inpatient hospital assessment
- the LTCH should request the geriatric mental health outreach team be involved on an ongoing basis to enhance learning related to their clinical consultation

Note: The Canadian Coalition for Seniors' Mental Health (CCSMH) recently published evidence-based recommendations for best-practice National Guidelines in the key areas of seniors' mental health. The Guidelines can be accessed at www.ccsmh.ca.

2.3 LTCH Decision-Making Guidelines Related to Challenging/At Risk Behaviours

A major challenge for LTCHs is determining behaviours that warrant transfer of a resident to a hospital. Currently each LTCH determines its own risk tolerance and there is not a consistent approach to managing challenging behaviours.

Please refer to page 20 for the Decision Tree. The Decision Tree is intended to:

- provide LTCHs with guidance on making decisions related to challenging behaviours

- be used with all behaviours considered challenging by the LTCH care providers and the resident's family/SDM
- support maintaining the resident in his or her home environment, and avoiding transfer to a hospital unless absolutely necessary

The LTCH must use its best judgment in applying the Decision Tree and the process can be modified or halted at any point if it is determined to be better for the resident's care. The LTCH's affiliated PRC can be contacted for knowledge to practice assistance at any time throughout the process.

Process:

Upon a resident display of challenging behaviour, the following steps should be considered:

1. Unit staff contacts the staff assigned to the behavioural support role.
2. Staff in the behavioural support role collaborates with the team in assessing the resident's emotional/psychological state.
3. Depending on level of risk, decisions are made as to future clinical management. Follow-up is the responsibility of the staff assigned to the behavioural support role or a designated Nurse Manager as identified by the LTCH.

Known, Predictable, Recurring Behaviour

1. Staff member assigned the behavioural support role reviews and up-dates resident's care plan.
2. Staff member assigned the behavioural support role reviews revised care plan with unit staff.
3. Unit staff implements the revised plan of care under supervision of the Nurse Manager/designate.
4. Staff member assigned the behavioural support role discusses issues with PRC if unit support/problem-solving/education needed.
5. Staff member assigned the behavioural support role monitors and evaluates resident behaviour.
6. If the behaviour does not change or improves (remains acceptable) the, care plan is monitored on an on-going basis.
7. If the behaviour escalates, new behaviours become apparent, or behaviour is generally unacceptable, the resident is referred to the attending physician for assessment.

Unexpected, New or Escalating Behaviour

1. Staff member assigned the behavioural support role contacts the resident's attending physician.
2. The attending physician conducts a physical assessment to determine if an underlying physical ailment that could act as a trigger for the behaviour, e.g. delirium. If required, the attending physician either refers the resident to external consultants, or transfers the resident to a hospital for further assessment.
3. The attending physician convenes a care conference with the interprofessional LTCH team and the resident and/or his or her family/SDM to discuss presenting issues, and goals to address the same.

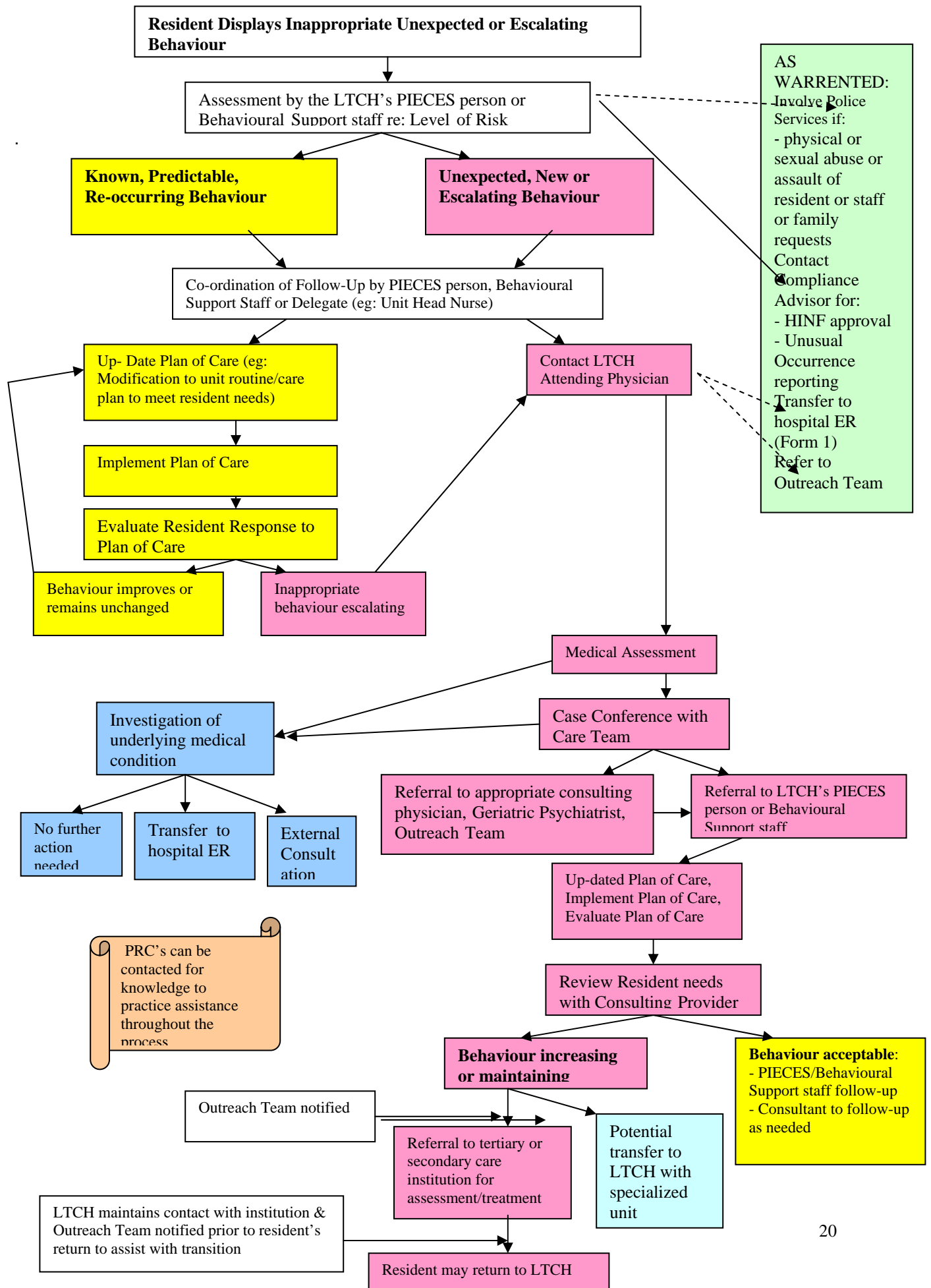
4. Possible decisions resulting from the care conference may include:
 - a. the attending physician refers the resident to the appropriate consulting physician, geriatric psychiatrist, or geriatric mental health outreach team
 - b. the staff member assigned the behavioural support role working with the external consultant up-dates and implement the resident's care plan;
5. For residents referred to a consulting physician, geriatric psychiatrist, or geriatric mental health outreach team, the staff member in the behavioural support role and/or the designated Nurse Manager is the primary LTCH contact for the consultant for follow-up on any consultant's recommendations.
6. If the behaviours in question remain acceptable, the care team, in collaboration with the staff member assigned responsibility in the behavioural support role continues to review and monitor the resident's behaviour with the consulting providers as required.
7. If the behaviours in question escalate, the staff member in the behavioural support role and/or the designated Nurse Manager contacts the consulting provider, and a decision can be made in conjunction with the family/SDM to refer the resident to:
 - a. a hospital for further assessment or
 - b. consider transferring the resident to another LTCH with a specialized unit (e.g. ethnocultural, secure unit), or to a specialized hospital program that may better meet the resident's needs
8. The geriatric mental health outreach team should be involved as required, to assist with the transition of the resident to and from the hospital/alternate LTCH.

Note 1: in a case of possible abuse or physical or sexual assault involving the resident, another resident, or staff, or if the resident or his/her SDM requests, and it is determined that the LTCH cannot wait for the geriatric mental health outreach team and/or other specialized service, the LTCH should:

1. contact Toronto Police Service;
2. request the attending physician to complete a Form 1 and transfer the resident to a hospital emergency room; and
3. contact the Ministry Compliance Advisor to report an Unusual Occurrence and/or request High Intensity Needs Funding in accordance with Ministry guidelines (if needed)

Note 2: Detailed information related to the LTCH's concerns should accompany all documentation when a resident is transferred to a hospital emergency room.

Note 3: The MOHLTC Compliance Advisor only needs to be contacted to report an Unusual Occurrence and/or request High Intensity Needs Funding.



3. Geriatric Mental Health Outreach Team Role

The primary focus (for this particular initiative) for geriatric mental health outreach teams is the relationship between the geriatric mental health outreach teams and LTCHs and CCACs, as CCACs have the responsibility for the LTCH application process.

Composition:

For the purposes of this Framework, a geriatric mental health outreach consists of a psychiatrist and at least one expert practitioner, e.g. registered nurse (RN), social worker (SW), occupational therapist (OT).

Services:

With LTCHs:

- provide consultation to LTCHs and the LTCH attending physicians for seniors identified prior to admission, as having known serious mental illness with related severe behavioural issues who were recently admitted to the LTCH, to assist the individual to successfully integrate into the home, and to help minimize related risks
- provide consultation to LTCHs and the LTCH's attending physicians regarding seniors not responding to interventions provided by the LTCH, and/or approved for High Intensity Needs Funding program supplementary staffing. This includes assessment, treatment, follow-up, and referral/access to other services for the resident as needed, as well as education for LTCH staff related to their clinical consultation

Education

Geriatric mental health outreach teams, LTCH PIECES staff and PRCs to work collaboratively to identify education needs of LTCH staff arising from clinical situations, so that the PIECES trained staff and the PRCs can provide relevant educational programs.

In the Event of Emergencies

Except in extenuating circumstances, LTCHs should contact geriatric mental health outreach teams in the event of an emergency only after consideration of the LTCH Decision Making Guidelines, and assessment of the resident by the LTCH attending physician, or his or her delegate. It is understood that there will be variances to this, based on urgent situations that arise in the LTCH.

The geriatric mental outreach teams should work collaboratively towards developing a mechanism(s) to provide LTCHs and CCACs with access to consultation, advice and support on a 7 day a week basis, 8 am – 8 pm.

Note: LTCHs in Etobicoke and North York can access geriatric mental health crisis support 24/7 through St. Elizabeth Health Care.

It is anticipated with the implementation of the Framework set out in the report, additional extended hours for phone consultation may not be required. The requirement for this resource should be tracked (i.e. frequency, day, time, reason) by the outreach

teams and evaluated by the geriatric mental health outreach teams and LTCHs, and at the MH/LTC System Advisory Group on a regular basis.

With CCACs:

- participate on any joint MLTC/MH mechanism that may be established to review and make recommendations for seniors on the LTCH wait list identified as “hard to place” due to behavioural issues related to mental illness, and who are waiting in place in the community
- participate in developing care plans for seniors with known serious mental illness with related severe behavioural response issues prior to their admission to the LTCH, to facilitate the transition of the senior from their current setting (e.g. home, hospital)
- provide consultation to seniors that the CCAC has identified as having symptoms of a serious mental illness with related behavioural response issues to assist the CCAC to identify appropriate LTCH placement and/or other services.

Community Agencies:

Provide geriatric mental health outreach services to community agencies serving seniors as feasible based on available resources.

3.1 Geriatric Mental Health Outreach Team and LTCH Alignment

The Committee developed goals and guiding principles to guide the process for alignment for geriatric mental health outreach teams with LTCHs (Refer to Appendix 10).

The Steering Committee recommended that:

- geriatric mental health outreach team/LTCH alignment include a process that allows for review and negotiation to enable relevant stakeholders to reach consensus, and
- a mechanism be in place to review the alignments on a regular basis to help ensure that existing alignments continue to reflect both the needs of the LTCHs, and the capacity of the geriatric mental health outreach teams

Note: As part of Ministry approval of implementation plans of the newly funded/enhanced Geriatric Mental Health Outreach Teams, the Ministry aligned the existing and newly funded Teams with the LTCHs and CCACs in July 2006.

4. Role of Solo Practitioners Working with LTCHs

Many LTCHs have existing relationships with geriatric psychiatrists or geriatricians (who are referred to in this document as solo practitioners) who currently provide consultation on an on-going basis to LTCH residents, and/or or engage these same, or other solo practitioners for residents who have diverse, complex needs and backgrounds on a temporary as needed basis. Other LTCHs may also wish to develop such relationships in the future. The Framework supports the continuing utilization of this valuable resource for LTCHs.

There will be situations where LTCHs have both solo practitioners and geriatric mental health outreach teams as external consultants. In order to ensure system resources are used effectively, it is recommended that the LTCH attending physician or delegate refer the resident to either the solo practitioner or the geriatric mental health outreach team.

The following issues have been identified related to more than one external consultant providing consultation for the same resident:

- availability of information
- conflicting management plans
- ability to facilitate a transfer of the resident to a hospital (in the absence of admission privileges)
- availability of geriatric psychiatrists not associated with a geriatric mental health outreach team

There may be certain clinical situations however, when it is appropriate for external consultants to collaborate in the care of a resident, e.g. expertise in ethnocultural matters, particular diagnostic expertise. In these situations it is recommended that:

- a Memorandum of Agreement be implemented describing the details of the relationship between the providers identifying:
 - geriatric mental health outreach Team staff to work with the solo practitioner
 - mechanisms for communication related to referral, treatment plans, outcome expectations, and meeting frequency
 - protocol for when the solo practitioner is not available in an emergency that confirms the solo practitioner retains responsibility for the resident's care

5. Role of Psychogeriatric Resource Consultant Program

The Psychogeriatric Resource Consultant Program consists of 11 Psychogeriatric Resource Consultants who are each aligned with LTCHs within the Toronto Region. PRCs provide education and knowledge on the care of seniors with dementia and other mental health issues to staff in:

- LTCHs,
- community services agencies and
- CCACs, and
- other programs.

The consultants are responsible for providing:

- provincial curriculum training: PIECES; U-First; Enabler; and
- traditional topic and case based education on a one-to-one, small group and team basis.

Referral to the PRC can be initiated by any LTCH staff member.

6. Role of Hospitals

Hospitals are a key component of the LTC/MH system, providing a range of services including emergency services, non-specialized inpatient mental health units, medical

geriatric units, etc. Generally these types of services are provided by local “acute care” schedule one facilities under the Mental Health Act.

Specialized geriatric mental health and behavioural management programs serving residents in Toronto LTCHs are located at the Centre for Addiction and Mental Health, Baycrest Centre, the Toronto Rehabilitation Institute, and the Whitby Mental Health Centre (WMHC). These specialized units can be accessed by referral from the LTCHs, and geriatric mental health outreach teams and PRCs can assist in the application process if necessary.

Hospital	TRI	CAMH	Baycrest	WMHC
	<u>Geriatric Psychiatry Service</u>	<u>Geriatric Mental Health Program</u> Geriatric Admission Unit Geriatric Continuing Care Unit	<u>Behavioural Neurology Short-term Inpatient Unit</u>	<u>Geriatric Mental Health Program</u> Seniors Mental Health Unit Seniors Memory Disorder Unit
Admission Criteria	Dementias with related behavioral problems Age: 65 years and over	<u>Admission Unit</u> - acute phase of major mental illness/addiction with related behavioral issues <u>Continuing Care Unit</u> - non acute phase of major mental illness/addiction which requires hospitalization (6-12 months) Age: 60 years and over	Cognitive and behavioural problems due to brain disease	<u>MH Unit</u> - complex mental health needs of seniors with serious mental illness, including refractory to treatment disorders. <u>Memory Disorders Clinic</u> – dementias with related behavioural issues Age: 65 years and over
Exclusion Criteria	Formed under Mental Health Act Medically unstable	Medically unstable IV Tube feeds, Oxygen ,Catheters	Medically unstable	Medically unstable Long term placement, interim placement while awaiting LTCH placement, respite care
Number of Beds	20	28 – Geriatric Admission Unit 20 – Geriatric Continuing Treatment Unit	20	50

Note 1: Not all hospitals providing specialized services are scheduled under the Mental Health Act. e.g. Toronto Rehabilitation Institute.

Note 2: Whitby Mental Health Centre’s catchment area includes Scarborough.

Note 3: Services descriptions, admission, and exclusion criteria are outlined in Appendix 11 and 11A.

Recognizing the complexity of the issues involved in accessing and coordinating admissions across LTC and hospital sectors, and keenly aware of the March 31, 2006 time frame, the Committee determined that:

- its efforts should focus on primarily on linkages/relationships with emergency room services, but also provide information on the hospital specialized programs as noted above.
- a recommendation be made that the Ministry/LHIN establish a process that will review and address the access and coordination issues (see Appendix 13B for the proposed Specialized Care Advisory Group)

Hospital Emergency Rooms/LTCHs

Anecdotal and survey information describes a LTCH system serving a significant population of seniors with serious mental illness with related behavioural response issues that frequently relies on transfers to hospital Emergency Rooms, Form 1s under the Mental Health Act, and calls to the Toronto Police Service to manage the most challenging behavioural response issues.

It is reported that LTCH residents are often transferred to hospital Emergency Rooms (ER) without adequate information related as to the reason for the transfer. In turn, LTCHs report that residents are frequently returned to the LTCH with no treatment and /or behaviour management plan to assist the LTCH staff to address the identified care/behaviour issues.

In an effort to improve communication between the LTCHs and ERs, the following protocols are recommended:

- that the LTCH documentation accompanying the resident being transferred to the ERs at a minimum, include:
 - similar information to that contained on the geriatric mental health outreach team referral form
 - a sticker with the name and phone number of the geriatric mental health outreach team
- that the LTCH notify the relevant geriatric mental health outreach team when a resident is being transferred to an Emergency Room

Emergency Rooms and Hospital Inpatient Services/ Geriatric Mental Health Outreach Teams

While acknowledging that avoiding Emergency Rooms is best for residents, and beneficial for the health care system overall, the Committee also recognized that crises will not be completely eliminated even with application of the Framework's recommended strategies. Geriatric mental health outreach teams can play a pivotal role in emergency rooms often by clarifying/enhancing LTCH information about a resident that can result in a more complete assessment of the resident's status, which may facilitate required transfers of LTCH residents to the appropriate clinical hospital service.

It is recommended that Geriatric Mental Health Outreach Teams:

- develop relationships with ERs, and relationships/partnerships with specialized hospital programs and in-patient units (to the extent possible) to facilitate required transfer of residents to the most appropriate care setting, and
- work with the LTCH attending physician to facilitate a resident's discharge back to his or her LTCH. For example, the geriatric mental health outreach team and the attending physician or delegate would jointly adapt the hospital discharge plan so that it is tailored to the LTCH's specific environment.
- Facilitate admissions to specialized geriatric mental health/behavioural management programs.

7. Role of Toronto Police Service

Toronto Police Service is often involved when a LTCH resident becomes violent, uncontrolled or wanders and/or when a Form 1 is used for a resident. It is important to ensure that Toronto Police Service is able to provide the most appropriate response in each situation. In most cases, this includes diversion of the senior with serious mental health with related behavioural issues from the justice system to the mental health system.

Recommendations:

1. LTCHs to contact Patricia Fleischmann, Toronto Police Services for further information related to the Toronto Police Service programs.
2. LTCHs establish relationships with their neighborhood Community Relations Officer or Crime Prevention Officer. (Refer to Appendix 5 for contact names.)
3. the Psychogeriatric Resource Consultation Program of Toronto will work with the Toronto Police Service to better understand and meet the learning needs of to the Toronto Police Service related to seniors with mental illness and behavioural issues

8. Role of Community Agencies Serving Seniors

While there are a number of community agencies in the LTC sector, and some in the mental health sector that have senior clients, many of these agencies do not have the mandate, or more importantly the expertise required to provide the assessment, treatment, and behaviour management programs that are required for seniors with mental illness with related behavioural response issues. In the mental health sector, the major providers are the Geriatric Mental Health Outreach Teams. However, as advised by Steering Committee community representatives, more and more seniors with mental illness are accessing agencies in both sectors. Quite frequently, these community agencies are grappling with similar service access issues and challenges that were previously identified by CCACs.

It was strongly suggested by the Steering Committee that geriatric mental health outreach teams do not have the capacity to meet the broad needs of community agencies serving seniors. The committee recommended that geriatric mental health outreach resources be focused on the LTCH residents as a key priority, and which is also consistent with the Committee's Terms of Reference.

To facilitate community agencies serving seniors ability to provide care to seniors with serious mental health and related behavioural issues, it is recommended that:

1. The PRCP continue to provide and increase its education efforts to the extent possible to community agencies.
2. A single centralized information line ('hot line') linked to the 4 hospitals with specialized geriatric mental health and/or behavioural management programs be established (e.g. Baycrest, TRI, CAMH, WMHC) to enable community agencies

to contact an expert on issues related to seniors with mental illness and related behavioural response issues.

3. Information on existing mental health crises services be made available to community agencies.

Acknowledging the great need of seniors living in the community including retirement homes who have serious mental illness and related behavioural response issues, the Steering Committee recommended that:

- a future Steering Committee be struck to advise and support the development and implementation of LTC/MH Framework to specifically address the needs of seniors living in the community

9. Linkages

Communication, collaboration and relationship building is encouraged among all participants. To that extent, it is recommended that:

- all LTC/MH system service providers are formally aligned through memoranda of agreement that clearly identify roles and responsibilities, referral mechanisms, communication strategies, and conflict resolution procedures, and
- the development of these agreements be guided by the roles, responsibilities, and protocols that have been outlined throughout the Framework.

The following section summarizes the relationships requiring such agreements.

LTCHs/Geriatric Mental Health Outreach Teams

The LTCH is responsible for:

- determining priorities and processes for referring residents for geriatric mental outreach team consultation
- ensuring referred residents have been medically screened for any physical conditions that may be causing/impacting on the resident's behaviour, e.g. delirium
- defining the referral process in consultation with the home's affiliated geriatric mental health outreach team. Flexibility on this process is recommended.

LTCHs/ External Consultants

- LTCHs to flag all consultations in the resident's chart, including identification of the consultant, date, action recommended, and impact of the recommendations
- the LTCH attending physician or behavioural support staff to notify the external consultants of the status and impact of their recommendations

LTCH/ Hospital Emergency Services

- The LTCH is responsible for ensuring that documentation accompanying the resident being transferred to the ERs at a minimum, includes:
 - similar information to that contained on the geriatric mental health outreach team referral form
 - a sticker with the name and phone number of the geriatric mental health outreach team

- notifying the relevant geriatric mental outreach team when a resident is being transferred to an Emergency Room

LTCH/Hospital Specialized Programs

- LTCHs will continue to apply directly to hospitals for admission for specialized assessment and treatment for their residents
- implementation of regularly scheduled meetings of representatives from each of the hospitals with specialized geriatric mental health and/or behaviour management services, LTCHs, PRCP, and geriatric mental health outreach teams to facilitate service coordination/linkages for access to hospitals, promote consistency, and resolve system problems

Geriatric Mental Outreach Teams /PRCs

- the geriatric mental health outreach team and PRC will jointly develop relationships and processes to work collaboratively in LTCHS
- the geriatric mental health outreach team will work with the LTCH staff and the PRC to identify educational topics to be provided by the PRC

H. Ethnocultural and Diversity Considerations

It was recognized that currently culturally appropriate resources are fragmented in the system. While there are resources available, without a mechanism to coordinate the existing information and make it widely available, providers have little access to existing resources to assist their clients. An inter-face for enabling framework service providers to access culturally focused services is needed.

Recommendations:

- That representatives of the geriatric mental health outreach teams, LTCHs, PRCP, and those mental health services with ethnocultural competencies form an advisory group to design a support system for LTCH residents that facilitates the access of resources to provide ethnoculturally responsive services.
- The initial focus of the Advisory Group should be to establish a centralized approach to:
 - developing an inventory of existing resources
 - identifying gaps
 - identifying a process to access existing resources at point of care and collectively and collaboratively address LTCH care guidelines

G. IMPLEMENTATION AND SUSTAINABILITY OF THE LTC/MH FRAMEWORK

To facilitate and support both the implementation and sustainability of the Framework, the Steering Committee recommended that four Advisory Groups be established and lead by stakeholders, including members of the LTC/MH Steering Committee. Suggested Terms of Reference are listed in Appendix 13A, 13B, and 13C. The Advisory Groups are:

1. LTC/MH System Advisory Group: to review issues related to the LTC/MH Framework to ensure on-going sustainability and resolve issues.
2. Specialized Care Advisory Group: to consider access, coordination, bed management, and any other identified issues relating to hospital specialized programs serving Toronto.
3. Wait List Review Advisory Group to review:
 - 1) The clinical needs of seniors who have been deemed eligible for placement in a LTCH and are awaiting placement and have serious behavioural issues that may be associated with serious mental illness and,
 - 2) System/policy issues related to LTCH placement (e.g. marketing, specialized units)
4. Ethnocultural Advisory Group: to facilitate effective use of existing ethnocultural and diversity services and programs.

I. Evaluation

Recognizing that the LTC/MH system will change over time, on-going performance measurement of the system should occur. To facilitate this review, it is recommended that the following indicators/performance measures be collected, analyzed and reported on a semi-annual and annual basis:

- number of seniors on the LTCH waitlist identified as 'hard to place' (source: CCAC)
- number of reported assaults by LTCH residents (source: LTCHs/Toronto Police Service)
- number of requests for Toronto Police Service interventions
- number of unusual occurrence reports related to residents with serious mental illness with related serious behavioural response issues (source: MOHLTC)
- number of High Intensity Needs Forms submitted for seniors with serious mental illness and related serious behavioural response issues (source: MOHLTC)
- number, day, time, and reason for Outreach Team emergency phone consultation (source: LTCHs)
- number of seniors with serious mental illness and serious behavioural response issues transferred to an Emergency Room using a Form 1 (source: LTCHs)

A data collection system is required to collect the necessary data from the multiple sources.

Recommendations:

- that the LHINs, or an academic center take on the responsibility for the collection, analysis, reporting of the data and facilitation of the changes needed to maintain the viability of the Framework.
- that within one year, a formative evaluation of the Framework to determine if the Framework is achieving its intended goals and objectives.

J. Conclusion

The Steering Committee gratefully wishes to thank the many stakeholders who worked tirelessly to put forward this report, including the Working Group participants, many of whom were not members of the Steering Committee. Appendix 15 lists all members of the four Working Groups.

Recognizing the value of the many excellent ideas identified by the Steering Committee and its Working Groups for improving the effectiveness of the LTC/MH system, but were outside of the scope of the Committee's mandate, it is recommended that these strategies listed in Appendix 4 be adopted by future Committees/Taskforces.

Appendix 1

Long-Term Care Homes/ Mental Health Steering Committee
Terms of Reference

November 4, 2005

Purpose and Scope

The Toronto Region Steering Committee will provide advise and support the development and implementation of a Toronto Region framework of Geriatric Mental Health Outreach Teams, psychogeriatric inpatient assessment/treatment programs, LTC Homes, CCACs, hospitals, Psychogeriatric Resource Consultants, and physicians, for seniors with serious mental illness and severe behavioural issues who:

- reside in Long Term-Care Homes,
- are being assessed by a CCAC for admission to a Long Term Care Home and/or
- live in the community and are provided services by a senior community agency(s).

The Steering Committee is expected to foster an environment of collaboration and continuing education to assist in ensuring the sustainability of changes to the health care system resulting from the framework.

Steering Committee Roles and Responsibilities

The Steering Committee will advise and provide support to the agencies and hospitals to:

1. establish core Geriatric Mental Health Outreach Team services, performance deliverables, and admission/ discharge/referrals/follow-up protocols
2. clarify at the Behavioural Management Unit at Baycrest Centre, the Geriatric Psychiatry unit at TRI, the Geriatric Mental Health Program at CAMH, and any other hospital unit so identified the:
 - roles and
 - admission/discharge/referral and follow-up procedures
3. recommend strategies to identify 'at risk' seniors with serious mental illness and severe behavioural issues in the community or LTC Home and appropriate response protocols
4. review CCAC assessment processes for admission to LTC Homes to recommend improvements required to identify LTCH applicants exhibiting serious mental illness and severe behavioural issues, including referral to Outreach Teams as appropriate
5. enhance LTC Homes' ability to meet the needs of this population through matching Outreach Teams to LTCHs based on:
 - LTC Home needs (type and level of service the home currently offers and expectations of the Outreach Teams)
 - capacity of the Outreach Teams

6. review the role of family physicians/geriatricians/geriatric psychiatrist/psychiatrists to support this population in LTC Homes as appropriate
7. clarify the role and responsibilities of the Alzheimer Psychogeriatric Resource Consultants Programs in LTCHs and CCAC considering the Steering Committee ToR.

Membership

Chairs:

Dr. Carole Cohen, Sunnybrook Health Centre (Mental Health), Co-chair
 Sandra Pitters, Homes for the Aged, City of Toronto (LTC), Co-chair

Members:

1. Margaret Buck, St Elizabeth Health
2. Sue Chattha, Elm Grove Living Centre
3. Dr. David Conn, Baycrest Centre
4. Delores Ellerker, Etobicoke Services for Seniors
5. Dr. James Edney, Medical Director, Toronto Home for the Aged
6. Dr. Corrine Fischer, St Michael's Hospital
7. Pam Goldsilver, COTA *
8. Gaby Golea, Centre for Addiction and Mental Health
9. Stephen Herbert, Baycrest Centre
10. Dr. Barbara Liu, Regional Geriatric Program of Toronto and Alzheimer Psychogeriatric Resource Consultation Program of Toronto
11. Sally McMackin, Psychogeriatric Outreach, UHN
12. Cecilia Meawasigeige, Spencer House
13. Carol Millar, Toronto CCAC
14. Mary Nestor, Central Care Corporation
15. Penny Pashby, Toronto Rehabilitation Institute
16. Angela Robertson, Sistering
17. Dr. Joel Sadavoy, Mt. Sinai Hospital
18. Jennifer Scott, North York CCAC
19. Ann Stephens, Geriatric Emergency Management, St. Michael's Hospital
20. Florence Wong, Yee Hong Centre for Geriatric Care
21. Clara Tsang, Rouge Valley Health System
22. Sharon McIlveen, Rouge Valley Health System
23. Jennifer Cameron, Scarborough CCAC
24. Dr. David Ryan, Psychogeriatric Resource Consultation Program of Toronto
25. Patricia Fleischmann, Toronto Police Services

* Resigned

MOHLTC Toronto Region

Marnie Weber, Regional Director (Ex-officio)
 Elaine Kuretzky, Project Manager
 Nello Del Rizzo, Program Manager, LTC
 Janice Buchanan, MH and Addiction Consultant
 Vania Sakelaris, LTC Consultant

Responsibility of Members:

- Participate in all scheduled Steering Committee meetings/teleconferences
- Participate on Steering Committee working groups
- Provide relevant information (e.g.: literature reviews, protocols, policies, references to experts) to support the project
- Review information and provide feedback/input within seven business days

Location of Meetings:

MOHLTC Toronto Region Office, 55 St. Clair Avenue West, 8th floor. (Sub-committees can use Toronto Region boardrooms or ministry teleconferencing services).

Preparation of Agenda/Minutes/Committee Support:

MOHLTC Toronto Region Office in consultation with co-chairs

Reporting Requirements

Interim Report by February 1, 2006 and Final Report by March 31, 2006

Appendix 2
LTC/MH
Program Logic Model

Mission	Transparent, coordinated system that recognizes LTCH accountability for residents and clarifies/strengthens relationships between stakeholder practitioners/organizations to provide services to seniors with serious mental health and severe behavioural issues					
Values	Integration, LTCH accountability, stakeholder driven, best practice based, value for existing resources					
Components	Stakeholder Roles & Responsibilities	Alignments	Access	Linkages	Resources & Inventory	Evaluation
Activities	<ul style="list-style-type: none"> - identified roles for: CCACs, LTCHS, Outreach Teams, PRC, hospitals, solo practitioners - LTCH internal management roles (e.g. Behavioural Support Role) and processes set out 	<ul style="list-style-type: none"> - alignments clear between Outreach Teams/LTCH; Outreach Teams /CCAC; solo practitioners/LTCHs; PRC/LTCHs/ police/LTCHs; - processes for dev/maintaining alignments set out 	<ul style="list-style-type: none"> - means to refer to CCACs, LTCHs, hospitals, Outreach Teams, solo practitioners, PRC, and police are clear - Outreach Team emergency coverage processes 	<ul style="list-style-type: none"> - Advisory Groups established and maintained 	<ul style="list-style-type: none"> - tools developed and distributed (e.g. draft MOU, Decision Tree, list_of multicultural resources) 	<ul style="list-style-type: none"> - monitoring indicators identified - data collected - data analysed - results reported
Short Term Outcomes (1-3 years)	<ul style="list-style-type: none"> - decreased duplication - increased appropriate utilization of resources - decreased unnecessary hospital transfers - increased stakeholder /staff satisfaction 	<ul style="list-style-type: none"> - improved care planning effectiveness - decreased wait lists - decreased assaults/incidents - decreased staff incidents 	<ul style="list-style-type: none"> - decreased time to access specialized services Outreach Teams, (and police if necessary) - quick access to inpatient specialized units when needed - increased support to LTCHs 	<ul style="list-style-type: none"> - on-going issue identification and resolution - system sustainability 	<ul style="list-style-type: none"> - increased awareness of resources - increased competency - increased capacity 	<ul style="list-style-type: none"> - increased stakeholder awareness of performance - LTCH system change
Long Term Outcomes (3-5 yrs)	On-going sustainable change					
Vision	Seniors with serious mental health with related severe behavioural issues in LTCHs receive needed, appropriate ethnoculturally sensitive care in a timely fashion, resulting in avoidance of unnecessary transfers to hospital Emergency Rooms.					

Appendix 3

Summary of Consultations on the LTCH/MH Framework

General Comments:

- over-whelming support for approach – recognition of the need for clear roles and responsibilities
- repeated requests for strategy for LTCH residents under 55 (i.e.: Huntington’s, ABI, dual diagnosis) and individuals in the community with MH and behavioural issues

	Consultation	Date	Issues
1	MOHLTC Community Health Division ADM and Directors	May 16, 2006	<ul style="list-style-type: none"> - include as outcome: staff stability - note in absence of Outreach Team: role of hospital to provide advise to LTCHs - identify provincial implications /intersection with provincial plans to ensure consistency (e.g.: ER PIECES program, Decision Tree) - set out plans to ensure sustainability - present to Steini Brown and Hugh MacLeod re: accountability
2	OANHSS, OLTC	May 24, 2006	<ul style="list-style-type: none"> - Psychogeriatric Intervention Criteria: make explicit that includes dementia and substance abuse - less emphasis on diagnosis and focus on behaviour - set out difference between secondary/acute and specialty/specialty hospitals - describe Behavioural Response Units - set out how Framework fits with LHINs - align with provincial directions - set out funding (e.g.: Behavioral Support Nurse) - consult to assure acceptability - change name of Behavioural Support Nurse – focus on functions – note similarity to Occupational Health and Safety Nurse, Infection Control Nurse, Skin Care Coordinator
3	Toronto Region LTCH Administrators	June 7, 2006	<ul style="list-style-type: none"> - queried LTCH support after 8pm - suggest consult with Ministry of Labour (MoL) – MoL inspects LTCHs and is reviewing incidents of violence - consult Ontario Safety Association (excellent web site) - outstanding issue: follow-up for patients referred to a specialty hospital that the Outreach Team is not affiliated with
4	University of Toronto Division of Geriatric Psychiatry	June 9, 2006	<ul style="list-style-type: none"> - set out number of beds and access to specialty hospitals - identify means to access independent geriatric psychiatrists - recommend modification of legislation to enable hospitals/LTCHs to assess patients directly for placement and facilitate appropriate placement (to minimize inappropriate placement choices) - noted: least desirable homes tend to “fill up” with patients with behavioural issues - consult Elder Abuse Network – similar mandate to Wait list Advisory Group - review data currently being submitted by Outreach Teams as part of MIS

5	Toronto Region RNAO Best practice Guidelines Implementation Steering Committee	June 13, 2006	<ul style="list-style-type: none"> - identified issues: <ul style="list-style-type: none"> - increase demand on LTCHs to accommodate seniors with MH issues due to cutback on MH beds in 80s/90s - insufficient resources for LTCHs (funding, training, staffing) - ethnocultural issues including language barriers and assessment tools often only in English - inadequate LTCH plans for residents discharged from an acute care setting - suggest Outreach Teams need to visit LTCHs 1 day/week - PRCs seen as key to implementation phase
6	Toronto Region Staff	June 15, 2006	<ul style="list-style-type: none"> - consider SHRTN - the Seniors Health Research Transfer Network - MASA – unsure it currently exists - recommendation that HINF should fund increased supervision for longer than 3 days
7.	Toronto Region CCACs	June 15, 2006	<ul style="list-style-type: none"> - requested Outreach Team assistance for community clients in ER - needs of dual diagnosis population not addressed in the Framework - suggested consulting consumer groups: (Concerned Friends, Ontario Association of Residents' Council, Family Councils project) 0 – suggested revising Framework over-vie slide to reflect that clients enter system through the CCAC - perceived COTA waitlist as a barrier - noted St Elizabeth Health Care has limited funding - recommend investigating the Hamilton CCAC model (part time geriatrician and psychiatrist engaged) - noted additional resources in community could decrease need for LTCH placement (premature admissions) - high-lighted ethnocultural issues and need to build linkages with existing resources - identified CCAC and agency issues: staff turn-over, part time staff, skill sets, lack of education on MH issues
8	The Toronto Police Service Toronto Emergency Medical Services	June 16, 2006	<ul style="list-style-type: none"> - EMS can modify data collection process to add new indicator to collect data on Form 1 transfers - EMS willing to develop new process and forms so that EMS will transport the client/patient/resident to a specific setting for a pre-arranged admission (involves development of new form) - investigate mandate of mobile crises units (e.g.: TPS Crisis Unit located at St Joseph Hospital; St Michael's unit, Scarborough General unit) – are they an available resource for LTCHs in the evenings? - suggested including MCIS (Multicultural Interpreter Services) as a resource in the report - noted language line services are available through 911 - recommended investigating the Concerned Friends project on diversity - noted benefit of GEM nurses in ER departments
9	Toronto Region Physicians	June 19, 2006	<ul style="list-style-type: none"> - attended by Toronto Police Team Mental Health Mobile Crises Unit Team member – operates 1pm – 11pm, 7 days per week – will go into LTCH for crisis intervention, currently operating in 51/52 and 11/14 Divisions

			<ul style="list-style-type: none"> - identified education for primary care physicians in LTCHs as needed; Ontario LTC Physicians, Alzheimer Strategy, and new group forming out of University of Calgary offer specialized education - recommended MOUs between LTCHs and hospitals for hospitals to provide back-up to LTCHs - concern identified that the report is not addressing quality of life - recommended that CMI criteria be amended to include serious mental illness and severe behavioural issues - issue identified that LTCHs decide who is referred to the Outreach Teams – the need for Outreach Teams to be able to influence the prioritization of patients referred to Outreach Teams was highlighted - noted the Behavioural Support Nurse could be a social worker – need to stress functions not name - emphasized role of solo practitioners – need for communication between all parties was stressed - questions whether age criteria for Baycrest would continue - LTCH physicians who review applications for LTCH admission looking to see that the applicant is stabilized - physician concern identified that no additional monies/sessional fees available – may impact success of Framework
10	Toronto Region Hospitals Toronto Central LHIN Central East LHIN Central LHIN Mississauga Halton LHIN Central West LHIN	June 28, 2006	<ul style="list-style-type: none"> - lack of senior addiction specialist in the community identified - new smoking by-law causing system blocks - identified lack of specialized units in the system - identified that some homes take more seniors with serious mental illness and severe behavioural issues than others - want assurance that LTCHs will accept resident back after hospital stay - noted that communication and relationship building is key - requested sample MOUs - all expressed interest in joining Advisory Groups
11	Mental Health Leads	July 5, 2006	<ul style="list-style-type: none"> - noted that in Clark Best Practice paper (1997) acute care hospitals were to be the gate keeper to specialty hospitals - request from other regions to adopt the Framework
12	City of Toronto Toronto Central LHIN Central East LHIN Central LHIN Mississauga Halton LHIN Central West LHIN	July 11, 2006	<ul style="list-style-type: none"> - discussed role of LHINs with Framework – noted that RO sponsored and RO closing – relying on LHINs to follow/evaluate/revise in the future - discussed link with corporate approach to seniors with serious mental illness and severe behavioural issues (i.e.: provincial Expert Panel) - discussed equity throughout the province – resources available in Toronto Region not necessarily available throughout the province
13	Toronto Police Service PRC	July 17, 2006	<ul style="list-style-type: none"> - recommended contacting the Public Guardians Office - suggesting contacting CONNEX and Advocacy Centre for Seniors - PHIPA issues:

			<ul style="list-style-type: none"> - is an issue for Police – example: individual with mental health issues directing case workers not to talk to Police - Circle of Care does not include the Police - RGP investigating PHIPA issues - P. Fleischmann contacting Police Services legal unit (Ottawa Police Service relying on section 41 of legislation to acquire needed information – requires Police to write letter to holder of information) - identified that isolated seniors are one of their greatest concerns - Police visit LTCHs on regular basis on proactive basis to prevent future calls - Police data available for 911 calls, Community Officer interventions, MCIT, ETF and general calls, e.g.: over 2,000 EDP (Emotionally Disturbed People) calls/month (however, only know if senior if manual search) - language capability is an issue – often need translators – would like to see best practice and policy for individuals with limited or no ability to communicate in English - identified need for list of resources in the community (no community system); each officer has his/her own list - referred to CONNEX (circulating laminated card with 1-800 number to access services) - identified that retirement homes are becoming similar to LTCHs with common issues - would like to see improved monitoring on secure floors (videoing) - suggested more mobile crises teams separate from Outreach Teams; noted currently funding Mobile Outreach Teams through 05/06 Accord Funding (in Divisions 51/52 and 11/14, 43 starting this week, North York expressing interest) - commented on usefulness of GEM nurses on diverting admissions - Police Service has Victims Service that is called mainly about senior abuse; noted no place for seniors to go – no senior shelters - potential City LTCHs/Police Service pilot project: City LTCHs to provide week-end relief for seniors to allow CCAC to intervention on Monday - example of system working: Division 22 Police have been provided with phone numbers for Sunnybrook crisis co-coordinators to enable officers to call ahead, have security available at the door; this has resulted in decreased Form 1 time to average of 19 min - PRC role: <ul style="list-style-type: none"> - focus on developing skills and knowledge of providers in LTCHs, CSS agencies, CCAC case managers, - involved with families on LTCHs - developing curriculum for specialized populations (e.g.: shelter workers) - going to develop curriculum for Toronto Police Service: complete knowledge to practice strategy (videos, working with decision-makers, college sessions)
14	Fiona Dalziel, Project Manager Ministry of Labour	July 19, 2006	<ul style="list-style-type: none"> - discussion focused on the Occupational Health and Safety Act and related regulations in LTCHs. - the Act covers such issues/activities as: use of equipment, ergonomics, safe working conditions, use of personal protection, dealing with aggressive patients, etc. It focuses on policies and procedures, existence of Joint health and Safety Committee, etc; a quality

			<p>assurance program is not a requirement. The Act/regulations also focus on the staff and environment - no focus is on the LTCH resident.</p> <ul style="list-style-type: none"> - Ministry of Labour utilizes a risk based monitoring approach (using WSIB data) and focuses on only high risk sites (worst performing sites); sites can be visited based on complaints. - Ministry of Labour does not provide guidelines or assistance to any organizations - this is provided by Ontario Safety Association and Health Care (OSAH), web site is: www.OSAH.ca. OSAH provides consultation services to organizations and develops teaching tools, guidelines, etc. including booklets on managing workplace aggression and related training programs. - Ministry of Labour is working with MOHLTC (LTCH Branch).
15	Toronto Region Community Support Services	July 27, 2006	<ul style="list-style-type: none"> - recommended contacting Ethnocultural Council of Canada - identified barriers: - noted Framework does not address community clients not linked to a CCAC - identified barrier: community clients with severe mental health and serious behavioural issues will not consent to LTCH placement, and when agreeable, difficult to find home
16	LTCH Advocacy Groups (Concerned Friends of Ontario, Association of Residents' Councils, Family Councils Project, Public Guardian and Trustee	August 18, 2006	<ul style="list-style-type: none"> - staff need to be knowledgeable of HCCA: Consent and Capacity Board to be consulted when family/SDM are working in best interest of senior, need to incorporate: Advance Directives and Power of Attorney directives - need to consider impact of resident with mental health and behavioural issues on other residents

Appendix 4

Related Recommendations Beyond the Scope of the Steering Committee

Recommendations include:

1. A second phase of the LTC/MH Framework Committee be struck in the future to address the needs of seniors living in the community including retirement homes, who have serious mental illness and serious behavioural issues.
2. Development of a communication strategy to allow for a free flow of information between providers to address the often inefficient or not communicated client information due to:
 - lack of secure method of transfer
 - lack of systematic, consistent, means of collecting and reporting information
3. Implementation of a specialized care unit in the LTCH sector for residents who have ongoing and serious at risk behaviours that cannot be safely managed in current LTCH settings. Access to this level of care will allow LTCHs to provide safe and effective care for all of their residents. These units, while providing a LTCH environment would:
 - be staffed appropriately, i.e. number of FTEs and expertise
 - be environmentally appropriate for the population, and
 - allow for transfer of resident between a hospital and the LTCH as needed.
4. LTCH placement regulations be modified so that LTCH applicants who can best be managed in specific LTCH units due to clinical or ethnocultural issues, be given priority for placement in those LTCH units. It is recognized that this would require a minimum set of criteria for designating specialized units that would take into account clinical, social, and ethnocultural programs offered, and staffing levels.
5. The issue of remuneration for physicians working in the community be examined in greater detail so that the nature of their work is better understood, for example the extensive time spent on indirect care including care coordination and knowledge transfer (e.g.: clinical conferences, chart reviews, supervision of clinical personnel).

Appendix 5
Geriatric Mental Health Outreach Team/LTCH and CCAC Alignments

Outreach Team	Aligned LTCH and CCAC
North York General Hospital	<p>LHIN 8 Carefree Lodge Cheltenham Extendicare Bayview Seniors' Health Centre Valleyview Residence The Gibson LTC Centre Cummer Lodge</p> <p><u>CCAC</u>: North York</p>
St. Joseph's Health Centre	<p>LHIN 7 Castleview Wychwood Copernicus Lodge White Eagle Nursing Home</p> <p>LHIN 6 Highbourne Lifecare Centre Labdara Lithuanian Nursing Home</p> <p><u>CCAC</u>: Toronto</p>
St Michael's Hospital	<p>LHIN 7 Belmont House Drs. Paul and John Reikai Centre Versa Care, Toronto Main Wellesley Central Place Nisbet Lodge Heritage Nursing Home True Davidson Acres</p> <p><u>CCAC</u>: East York</p>

Outreach Team	Aligned LTCH and CCAC
Sunnybrook	<p>LHIN 7 Isabel and Arthur Meighan Suomi Koti</p> <p>LHIN 8 Thomson House</p> <p>CCAC: Toronto</p>
UHN	<p>LHIN 7 Castleview Wychwood Towers Christie Gardens Fudger House Hellenic Care for Seniors Kensington Gardens Leisureworld Caregiving Centre – St. George Lincoln Place Vermont Square CCAC: Toronto</p>
TRI	<p>Castleview Wychwood Towers Extendicare Lakeside Mon Sheong D’Arcy St. site O’Neill Centre</p>
Toronto East General Hospital	<p>LHIN 7 Ina Grafton-Gage Home for the Aged St. Clair O’Connor Community Nursing Home</p>
Baycrest	<p>LHIN 7 Baycrest Centre/Jewish HFA</p> <p>CCAC: North York</p>
Whitby Mental Health Centre	<p>LHIN 9 Altamont Nursing Home Extendicare Guildwood Trilogy</p>

Appendix 6A

Results of Electronic Survey

LTC Homes:

The LTCHs report that 32.5% of residents over 55 display serious mental illness and severe behavioural response issues. In the past 6 months:

- 1 LTCH used a FORM 1 +5 times; 47.9% used a FORM 1 1-3 times; 43.8% did not use one
- 52.8% called Toronto Police Service 1-3 times; 40.3% did not call Toronto Police Service or private security
- 35.6% contacted a Compliance Advisor related to a resident behavioural issue; 64.4% never contacted a Compliance Advisor

Fifty six percent of LTCHs (42 LTCHs) reported a specialized care unit/secure unit for residents with behavioral issues, with a total reported capacity is 1893 beds. Characteristics of these units included: special programs (76.2%), physical characteristics (62%), increased number of other staff (57.1%), established relationships/agreements with external service providers (38.1%) and increased number of regulated staff (23.8%).

Most LTCHs (93%) report having PIECES trained staff; LTCHs that lacked PIECES trained staff generally did so due to staff turn-over. In general LTCHs had 1 – 3 PIECES trained staff (0 (8.8%), 1 (20.6%), 2 (22.1%), 3 (22.1%), 4 (7.4%), 5 (13.2%) or greater than 5 (5.9%)). Very few LTCHs had PIECES trained staff that worked all 3 shifts (days (46%), days and evenings (41.3%), all 3 shifts (12.7%)).

The majority of LTCHs had not established an internal in-house resource team (yes: 46.7%, no: 53.3%). Of the respondents who have a team, only 35.6% allocate specific time and resources to the team. Very few LTCHs have integrated PIECES/U-First into day-to-day practice and policy.

All LTCHS provided education on dementia to registered staff/PSW/HCA, but only 74.3% to other staff. The majority (70.3%) provided education on understanding mental illness to registered staff and PSW/HCA staff, but only 45.9% to other staff. Approximately 90% provide education on managing resident behaviours that create disruption to registered staff and PSW/HCA, but only 59.5% to other staff

PRCs provide the majority of education (52%); in-services are the next most common (33.3%). Very few LTCHs (13%) have an MOU with PRCs and fewer (10.7%) with a hospital to transfer residents. Approximately half of the LTCH respondents (47.2%) have an agreement with a psychogeriatric or mental health provider.

Fifty six (56) LTCH respondents reported that geriatric psychiatrists provided services to their LTCH. Almost all geriatric psychiatrists (90%) provide specialized assessment, treatment plan development, and treatment follow-up. The majority (77%) provided consultation/education. The majority (89.2%) are available only during the day (1.8% evenings, 8.9% 24 hours, 0% week-ends). Average waiting time was a week or more (average wait times: 1-2 days=17.9%; <1 week=26.8%; >1 week=39.3%; other=16.1%).

Appendix 6B

LTC/MH Framework Electronic Survey Findings

Ministry of Health and Long-Term Care, Toronto Region
Long-Term Care/Mental Health Survey
August 2006

NOTES ON THE SURVEY RESULTS

Of the homes that responded to the survey, not all completed every question.

Please note that the percentages used describe the percentage of respondents indicated in each question, NOT the total number of long-term care homes.

The percentages generated by the SurveyMonkey.com website have NOT been used. 12 homes completed the survey twice, mostly due to different staff members from the same home responding. Only one response per question per home has been allowed in order to present the most accurate results possible. In cases where two responses to the same question by different staff members were not identical, numerical responses were averaged.

GENERAL INFORMATION

Question 121: Percentage of residents > 55 years/mental health problems/behavioural issues requiring mental health consultation
Average = 32.5% (69 respondents)

122: 84% of LTCHs document behaviours every 72 hour shift for every admission (75 respondents).

123: 62.5% of LTCHs have a policy for newly admitted/transferred residents with identified behavioural challenges (74 respondents).

124: Strategies that homes implement with a new resident identified with behavioural problems that may be a risk. (multiple answers accepted) (75 respondents)

Strategies	Percentage
Temporarily assign 1:1 staff	44.0%
Observe for 24 hours	85.3%
Immediately apply for HINF	24.0%
Other	54.7%

	<ul style="list-style-type: none"> • PIECES assessment • MD assessment • Behavioural assessment • Residents with documented aggressive behaviours not admitted – send to hospital within 24 hours of observation, or send to another facility • Request support from/Refer to Regional Psychogeriatric Consultant, physician, and/or behavioural support nurse • Involve family in support and identifying approach • Admit to our special care unit • Transfer to rehab • Form 1 if needed • Transfer to BRU if available • Close observation for 72 hours • Cohen-Mansfield • Psychiatric consult • Gentle Care Program • Behavioural mapping • RGP/Psychogeriatric Outreach Program/Psychogeriatric Teams • Document behaviour • Contact Social Worker, PRC, MD for medication assessment • Least restraint policy
--	--

125: CCAC assessed LTCH's capacity to care for patients with behavioural problems (73 respondents).

YES: 34.2%

NO: 65.8%

126: Does LTCH have a policy for residents if challenging behaviours emerge after initially settling? (75 respondents)

YES: 76%

NO: 24%

PIECES TRAINING

Question 127: LTCHs with PIECES trained registered staff (48 respondents)

YES: 85.4%

NO: 14.6%

128: Why no PIECES trained staff? (9 respondents)

Reason why not	Percentage response
New LTCH	0%
Staff turnover	66.7%
Never heard PIECES training	0%
Other	33.3%
	<ul style="list-style-type: none"> • Training did not provide frontline tools • In process

129: Number of PIECES trained staff (68 respondents)

Number of PIECES trained staff	Percentage
0	8.8%
1	20.6%
2	22.1%
3	22.1%
4	7.4%
5	13.2%
>5	5.9%

130: Shifts worked by PIECES trained staff (63 respondents)

Shifts	Percentage
Days	46.0%
Days and evenings	41.3%
All three shifts	12.7%

131-133, 135-139:

	YES	NO
Policies/procedure to support/sustain implementation of PIECES (73 respondents)	50.7%	49.3%
Policies to implement and maintain PIECES practices (75 respondents)	46.7%	53.3%
As a result of training in homes, there have been changes in practices dealing with residents (69 respondents)	79.7%	20.3%
LTCH has established an internal in-house resource team (75 respondents)	46.7%	53.3%
Does it include a PIECES resource person? (41 respondents)	73.2%	26.8%
Is there established specific time and resources dedicated to this in house resource team (45 respondents – 11.1% chose NOT APPLICABLE)	35.6%	53.3%
Has LTCH integrated PIECES/U-FIRST into day-day practice & policy (74 respondents)	35.5%	63.5%
Have any staff participated in PIECES ENABLER program? (75 respondents)	60%	40%

140: Why no PIECES ENABLER trained staff? (32 respondents)

Why no PIECES ENABLER trained staff	Percentage
New home	12.5%
Staff turnover	43.8%
Never heard of PIECES training	6.3%
Other	37.4%
	<ul style="list-style-type: none"> • No staff to cover for staff on training (financial resources) • Training time was missed • Not familiar with PIECES ENABLER training • In process

134: Number of staff sent for PIECES training (73 respondents)

Number of staff sent for PIECES training	Percentage
0	13.7%
1	19.2%
2	32.9%
3	19.2%
4	2.7%
5	5.5%
6	2.7%
>6	4.1%

OTHER EDUCATION

Questions 141-143: (74 respondents)

Other education	Registered staff	PSW/HCA	Other staff
Dementia care	100%	98.6%	74.3%
Abuse prevention/intervention	94.6%	93.2%	79.7%
Aggression management	87.8%	89.2%	64.9%
Managing resident behaviours that create disruption	89.2%	91.9%	59.5%
Violence in the workplace	44.6%	48.6%	43.2%
Understanding mental illness in older adults	70.3%	70.3%	45.9%
Other	25.7%	21.6%	16.2%
	<ul style="list-style-type: none"> • ABI • Huntington's • A&P of the brain • Gentle care • Communicating with the confused • Depression • Delirium • Schizophrenia • Sensitivity training • Non-violent crisis intervention • Suicide • Anxiety • Paranoia • Mood disorders • Hallucination • Addictions • Challenging behaviours • Other mental health topics • Ongoing in-service from PRC 		

144: (75 respondents)

The majority of respondents reported that the PRC provides the majority of education to staff of the LTCH (52%). In-service is the second most common provider (33.3%).

145: Information on Educational Sessions

16.7% of respondents reported that 91-100% of registered staff attend educational sessions. 16.7% of respondents also responded that 81-90% of registered staff attend educational sessions. (72 respondents)

18.9% of respondents reported that 81-90% non-registered staff attend educational sessions. (74 respondents)

These figures represent the most frequent responses given.

146: (72 respondents)

61.1% of the respondents report that registered staff attend monthly educational sessions and 51.4% of non-registered staff attend monthly education sessions.

These figures represent the most frequent responses given.

5.6% of the respondents report that registered staff attend annual education sessions and 8.3% of non-registered staff attend educational sessions annually.

147: (75 respondents)

92% of respondents report that they receive services from Psychogeriatric Resource Consultants (PRCs).

148:

Percentages based on the number of responses within the 69 respondents that answered YES to Question 147.

PRC services provided	Percentage
Consultation with staff on resident care	94.2%
Education/training of staff	95.7%
Assist in identifying and providing access to other services	66.7%

149-151:

Only 13.0% of respondents have a memorandum of agreement with PRCs (of the 69 respondents that answered YES to Question 147).

10.7% of respondents have a formal agreement with a hospital to transfer residents with behavioural issues. (75 respondents)

These LTCHs can transfer a resident to a hospital for both assessment and treatment. Hospitals listed: TRI, Scarborough Grace, West Park, RVHS – Centenary, CAMH – Queen Street, TWH, St. Mike's, TSH, SJHC.

47.2% of LTCHs have a formal agreement with a psychogeriatric or mental health provider. (74 respondents)

SPECIAL CARE UNITS

155-156:

56.0% of respondents have a specialized care unit/secure unit for residents with behavioural issues. (75 respondents)

The LTCHs with a specialized care unit/secure unit have a total capacity of 1893 beds.

Percentages based on the number of responses within the 42 respondents that have a specialized care unit/secure unit.

SCU characteristics	Percentage
Increased number of regulated staff	23.8%
Increased number of other staff	57.1%
Staff with extensive experience working with residents with behavioural issues	57.1%
Special programs (sensory stimulation)	76.2%
Physical characteristics	61.9%
Established relationships/agreements with	38.1%

external service providers	
Regular/ongoing specialized training for SCU staff	47.6%
Other	23.8%
	<ul style="list-style-type: none"> • Secure door (locked) • Music therapist • Complementary care therapist • Volunteers (cultural and spiritual needs) • Outreach teams • Monthly behaviour management team meetings • Case-based training from PRC, UHN social worker, psychiatrist • Bed alarm • Locked elevators • Wanderguards

61.9% of the 42 respondents that have a SCU/secure unit have specially trained staff. Only 19.0% of those respondents indicated that their SCU/secure unit has PIECES trained staff working days and evenings. Only 4.8% of the respondents indicated having PIECES staff for all three shifts. (Possibly 9.5%; there is some conflicting information between staff at the same homes.) Respondents commented that some PIECES staff are only called when a problem arises.

76.2% of the 42 respondents that have a SCU/secure unit have access to an external specialized psychogeriatric mental health resource other than a PRC. Of the 32 LTCHs where this is available, only 9.4% reported that they are available on all three shifts.

SAFETY

162: (73 respondents)

Over the past 6 months, 43.8% of respondents have never had to send someone to the hospital on a FORM 1 for behavioural problems. Only 1 home has had to send patients on a FORM 1 more than 5 times. 47.9% of respondents have had to send patients on FORM 1 1-3 times.

163: (72 respondents)

Over the past 6 months, 40.3% of respondents have never had to contact the police/hire private security/additional staff. 52.8% of respondents have had to call the police 1-3 times. Only 1 home has had to do so more than 5 times.

164: (73 respondents)

Over the past 6 months, 64.4% of respondents have never had to contact a compliance advisor on whether to readmit a resident transferred to a hospital for behavioural challenges. 34.2% of respondents have had to do so 1-3 times. Only 1 home has had to do so more than 5 times.

ADDITIONAL RESOURCES

Questions 167-174:

The number of respondents in each of these categories is determined by the number of respondents that identified the particular type of professional as one that provides services to the home.

Services provided	Percentage			
	Geriatric Psychiatrist (56 respondents)	Geriatrician (21 respondents)	Psychiatrist (5 respondents)	Other* (11 respondents)
Consultation/education	76.8%	81.0%	80.0%	81.8%

Specialized assessment	92.9%	90.5%	80.0%	72.7%
Treatment plan development	87.5%	81.0%	80.0%	100%
Treatment/care plan follow-up	91.1%	66.7%	40.0%	100%
Case management	62.5%	33.3%	40.0%	72.7%

	Percentage			
	Geriatric Psychiatrist (57 respondents)	Geriatrician (20 respondents)	Psychiatrist (5 respondents)	Other* (11 respondents)
Availability of services				
Working hours	89.2%	95%	75%	54.5%
Evenings	1.8%	5%	0%	0%
24 hours	8.9%	0%	0%	45.5%
Weekends	0%	0%	25%	0%
Average wait times				
1-2 days	17.9%	5%	25%	45.5%
< 1 week	26.8%	20%	0%	27.3%
> 1 week	39.3%	55%	0%	27.3%
Other	16.1%	20%	75%	0%

* "Other" includes attending physicians, MSWs, clinical nurse specialists, psychogeriatric outreach program, and PRCs.

ISSUES AND DESIRED OUTCOMES/SOLUTIONS

ISSUES:

Family

- Unreasonable care expectations of family members who lack knowledge or objectivity in regards to the behaviours of their loved ones
- Insufficient family support and education when dealing with residents exhibiting difficult or challenging behaviours

LTCHs

- Lack of time, financial resources, and other forms of support to provide care to handle residents with behavioural problems
- Limited volume of residents can be admitted
- Behavioural problems cause disruptions in all aspects of the entire home
- Lack of information on residents' mental health issues prior to admission
- Risk of litigation if residents with behavioural issues are admitted and become a safety risk to others in the home

Resource Access and Timelines

- Slow response time of specialists
- Slow response times for transfers in times where emergency crisis placement is needed
 - Multiple respondents have reported situations where patients have been returned to the LTCH from the receiving hospitals they were transferred to, and timely external resources were needed.
- Lack of in-home access to psychogeriatrician
- Limited social worker support for homes without in-home social workers
- Lack of 24-hour support in crisis situations
- Lack of formal agreements for support with hospitals, outreach teams, and psychiatrists

- Visits from psychogeriatricians are not frequent enough
- No resources for “young senior” and “mid-senior” population with mental health problems and behavioural response issues

Safety

- Managing behaviours can result in injuries to both staff and other residents
- Pressure from outside organizations (including the CCAC) to admit residents that may be a safety risk within the home, or would otherwise not be best served at a particular home

Staff

- Staffing levels and staff-to-resident ratios are not high enough to handle difficult behaviours
- Staff lacks knowledge of and familiarity with mental health problems and the handling of residents with challenging behaviours
 - PSWs do not have enough training in mental health
 - RPNs do not have enough psychiatry in their curriculum
- Lack of PIECES training

System

- Inaccurate pre-admission information that does not allow for appropriate pre-admission planning
- Lack of in-depth review in pre-admission

DESIRED OUTCOMES/SOLUTIONS:

Families

- Increased resources to educate families on the behaviours of their loved ones

LTCHs

- Improved environmental design
- More specialized units and bed space
- Funding increase to accommodate more time to residents that require additional care
- Increase in high intensity needs hours available to be funded

Resource Access and Timelines

- General awareness across the system of the increased amount of resources needed for this population
- More access to outreach teams in addition to after hours access
- Improved relationships with hospitals for crisis admissions, especially during off-hours
- Increased support from mental health specialists
- Reduction of waiting times and response times for support services
- More frequent visits to assess and reassess residents
- Formal agreements with hospitals, outreach teams, and psychiatrists
- One-on-one programs
- Outreach Teams supporting all homes
- Increase mental health leave to 60 days to allow adequate time for assessment and evaluation of the effectiveness of medication
- Establishment of an LTCH for “young senior” and “mid-senior” population with mental health problems and behavioural response issues
- Change in the current method of funding for LTCHs (e.g. behaviors not captured for CMI unless all documented each shift)

Safety

- Secure units for homes that do not currently have them
- Increased communication with the CCAC to educate them as to the activities of the LTCHs and the appropriateness of the admissions referrals made to the LTCHs, especially those that could potentially be safety risks to others

- Resources for additional staff at all times of the day to ensure the safety of other staff members and residents

Staff

- Increased resources for additional staff, for instance:
 - PIECES trained staff on all shifts
 - geriatrician to follow up on recommendations made by the PRC
 - in-house psychiatric team (e.g. psychogeriatrician)
- Improved staff-to-resident ratio
- Provision of more training and educational sessions to staff, including PIECES and other specialized topics

System

- Centralized case management to ensure as much accurate resident information as possible is available
- Common shared resources across all sectors (e.g. library, assessment forms)
- Pre-admission review of resident issues with PRC to develop care plans for immediate implementation on admission

Appendix # 7

LTC/MH Framework Objectives:

1. Supports the requirement for LTCHs to monitor and evaluate the LTCH resident's care, services and care outcomes on an on-going basis.
2. Promotes and supports the residents' autonomy and their involvement or their family/SDM involvement in decision-making regarding their care and service provision.
3. Helps to ensure all resident care plans include a strategy to effectively address the his or her linguistic and/or ethnocultural needs.
4. Focuses on early detection and intervention in disturbances of mental health
5. Is specific to Toronto Region and will utilize existing resources
6. Helps to ensure LTCHs are provided with necessary supportive mental health resources to enable them to provide effective care within the LTCH setting.
7. Helps to ensure all providers have clear, defined roles and responsibilities
8. Helps to ensure seniors in LTCHs with serious mental illness with related severe behavioural issues receive consultation, assessment and treatment by Outreach Teams, specialized in-patient programs, etc. in an orderly, timely manner as required
9. Helps to ensure all referral or review processes are clear to all service providers and occur in a timely manner.
10. Helps to ensure LTCH resident transfer to hospitals occurs only when essential.
11. Helps to ensure procedures are set out to assist LTCH staff in dealing with behavioural issues when a senior resident is in crisis.
12. Helps to ensure educational strategies are in place for staff and knowledge can be effectively translated into practice.
13. Help to ensure continuing evaluation of program implementation and foci of program improvements.

Appendix 8

Identifying Symptoms of Behavioural Response Issues

The Definition Working Group was charged with the task of developing criteria to assist in the identification of individuals with serious/challenging behavioural response associated with serious mental illness.

The Working Group determined that it was more feasible to develop a 'process' to assist with the identification of symptoms of severe behavioral response issues, rather than specific 'criteria'.

In reaching this conclusion, the Definition Working Group:

- a) conducted a literature search;
- b) drew upon examples of resident incidents;
- c) developed a draft tool to assist LTCHs in deciding whether specialized geriatric mental health services are required;
- d) piloted the tool and determined that further investigation would be required if it were to be used by LTCHs;
- e) reviewed the Group's work against the guiding principles tabled by the Framework Working Group to ensure consistency.

Appendix 9

Behavioural Support Role Functions

The behavioural support role involves co-ordination of outreach Team “clinics” in LTCHs, and follow-up that may be required from the Team’s recommendations for treatment and/or behavioural management. The “role” also acts as a link between the outreach Team and the staff on the resident’s unit with the following functions:

- linking with LTCH nurse managers to identify seniors requiring review by the Outreach Team
- prioritizing, with the LTCH nurse managers and Attending Physician, residents requiring review by the Outreach
- tracking co-ordination of all needed medical examinations prior to the Outreach Team review (e.g.: physical review)
- organizing the clinic (e.g.: timing, organizing resident availability)
- completing and/or ensuring completion of required documentation (e.g.: referral forms, substitute decision makers consent forms)
- forwarding all relevant documentation to the Outreach Team 1 week prior to the clinic for Outreach Team review
- ensuring all reports needed are available at the clinic (e.g.: the resident chart)
- ensuring the appropriate LTCH nurse manager and Attending Physician are informed of the Outreach Team recommendations
- on-going contact with the appropriate LTCH nurse manager to identify residents requiring re-review by the Outreach Team

Appendix 10

Goals for Aligning Geriatric Mental Health Outreach Teams with LTCHs

The Inventory Working Group confirmed details on existing Outreach Teams, e.g. staffing complements, catchment areas, LTCHs currently covered, and developed the following Goals and Guiding Principles for alignment with LTCHs:

Goals for Aligning Geriatric Mental Health Outreach Teams with LTCHs

1. Enhance client focused care of LTCH residents with serious mental illness and related behavioural response issues.
2. Build LTCH system capacity through effective and efficient use of Outreach Teams.
3. Promote *equitable* Outreach Team workloads and therefore *equitable* access to Outreach Team services by both the LTCHs and the community.
4. Enhance system integration through enhancement of Outreach Team/LHIN collaboration and partnerships

Guiding Principles for Aligning Geriatric Mental Health Outreach Teams with LTCHs

1. Every LTCH to be aligned with at least one Outreach Team.
2. For the purposes of this Framework, an Outreach Team consists of a psychiatrist and at minimum 1 other geriatric mental health practitioner (e.g. nurse, social worker, OT).
3. Outreach Teams to be aligned and integrated with system needs and priorities, considering wherever feasible:
 - prior/existing relationships,
 - LTCH bed numbers,
 - severity of illness of the residents (e.g. Special Care Unit), and
 - linguistic and/or ethnocultural needs
4. Alignments should be accomplished in a manner that:
 - o does not sever existing relationships that are working well. If changes are to be considered, there should be agreement by all involved parties,
 - o does not negate the need for two (2) or more teams to be involved in the same LTC home, if that best meets the needs of residents
 - o considers Outreach Team capacity with the following suggested benchmarks:
 - 1 expert full time practitioner – responsible for 4 LTC Homes
 - expert practitioner: visit each LTCH 1/week
 - psychiatrist: minimum visit each LTCH 1 /month

Appendix 11

Summary of Hospital Specialized Geriatric Mental Health/Behavioural Management Programs

CAMH – GERIATRIC MENTAL HEALTH PROGRAM

Available Programs: Inpatient and outpatient services.

Inpatient Services

- **Geriatric Admission Unit:**

A 28 bed unit focusing on individuals requiring acute stabilization of their psychiatric symptoms, crises intervention, and active treatment.

- **Geriatric Continuing Care Unit:**

A 20 bed unit focusing on individuals who although are no longer in the acute phase of their illness, still require hospital care. Longer stay from 6 – 12 months.

Outreach Services

- **Psychogeriatric Assessment, Consultation and Education (PACE)**

The mandate of the program is to maintain clients in the community for as long as possible, to prevent unnecessary hospitalizations, to provide consultation services to community partners, and to provide continuity of care to patients upon discharge from in-patient units.

Three PACE clinics (Pace Central/East, Pace West, PACE Peel) currently provide educational programs to long-term care facilities and community agencies.

Outpatient Service

- **Memory Clinic**

Individuals with known or suspected memory problems can be seen in this multicultural, multilingual memory clinic. The clinic operates 3 half days per week and effort is made to service individuals in their mother tongue.

Population Served:

- Individuals 60 years and older with long-standing or newly diagnosed psychiatric disorders, concurrent disorders, Alzheimer's type dementia.
- Individuals younger than 60 years of age suffering from an age-related dementia
- Medically stable
- Outpatient services have defined catchment areas
- The Geriatric Mental Health Program is unable to meet the needs of medically complex individuals requiring interventions such as intravenous therapy, tube feedings, central lines, and continuous oxygen.

Admission Process:

Admissions to inpatient and outpatient services are made through the Central intake person during business hours. Each referral is then reviewed by the manager of individual departments.

Existing Relationships:

Formal: CAMH ER has a formal agreement with Mount Sinai Hospital ER for medical clearance services.

Informal: Informal agreements exist with over 30 LTC facilities across Toronto for specialized consultation and support. Toronto Western Hospital (TWH) and St. Joseph's Hospital also provide medical clearance of individuals.

Referral Source:

Referrals are divided from both LTC homes (downtown Toronto, south Etobicoke, parts of East York, Peel Region) and from the community (individuals, family members, CCACs [Peel, Toronto], hospitals and family physicians).

BAYCREST CENTRE FOR GERIATRIC CARE

Behavioural Neurology Short-term In-patient Unit:

A 20 bed short-term in-patient unit focusing on assessment and management of adults suffering from brain disorders leading to abnormalities in cognition and behaviour. Common problems include memory loss, speech and language disorders and agitation. Services include neurological assessment, diagnosis and medication intervention, behavioural/cognitive management, education, counseling and referral and linkage to appropriate services and programs.

Admission Criteria:

Medically stable adults with cognitive and behavioural problems due to brain disease especially cognitive dysfunction, associated behavioural disturbances/agitation, amnesia and frontotemporal dementia.

Application/Referral Process:

Applications are sent directly to the admission office. Referrals are reviewed by a multidisciplinary team (psychiatrist, social work, nursing) and if approved are offered a bed, or put on a wait list. Applications are prioritized on the basis of urgency, bed availability, and date application received. Information required include CCAC application, completed neurology application form, note from referring physician, and all relevant assessment and consultation data.

Discharge:

Goals are determined by the client/family and multidisciplinary team. Patients are discharged when there is consensus that the goals have been achieved or that no additional progress would be achieved through continued inpatient treatment.

TORONTO REHABILITATION INSTITUTE: GERIATRIC PSYCHIATRY SERVICE

Admission Criteria:

- Diagnosis of dementia and related behavioural issues
- Medically stable
- 65 years of age and older

Exclusion Criteria:

Cannot be on any forms under the Mental Act.

Admissions Process:

Application form, medical form, consults are reviewed weekly by admission team consisting of psychiatrist, manager and member of interprofessional team

Referral Sources:

80% from Long-Term Care homes (Toronto, Peel and York Region), Outreach team and PRC

20% from Community: CCAC, hospitals, family physicians

Relationships:

Formal: none

Informal: UHN – TWH short stay emergency unit, UHN Outreach Team

WHITBY MENTAL HEALTH CENTRE

The Seniors Mental Health Program's role is to provide specialized mental health services to seniors, usually 65 years of age and over with age related complex and serious mental illness and their associated challenging behaviours.

Inpatient Services:**Seniors Mental Health Unit**

- provides specialized services to meet the complex mental health needs of seniors with serious mental illness including refractory to treatment disorders

Seniors Memory Disorder Unit

- specialized services to meet the mental health needs of clients with dementia, including effective management of challenging behaviour
- offer a full range of specialized resources to address the assessment, diagnostic, treatment and transitional care needs of seniors with complex mental illness.
- a comprehensive assessment is provided by a multidisciplinary team who focus on identification of mental health issues, clarify diagnosis, and identify possible factors that contribute to challenging behaviours

Criteria for Services**Inclusion Criteria**

Clients usually 65 years of age and older who are:

- medically stable, with a severe or complex aged related mental illness
- severe mental illness is refractory to treatment (requiring more than 2 courses of treatment) or chronic (requiring treatment for longer than 6 months).
- complex mental illness has two or more psychiatric diagnoses; co-morbidity with either psychiatric or physical needs causing excessive disability; exhibits risk of harm; exhibits major challenging behaviours.

Appendix 11 B

Inpatient Services are not for permanent placement, interim placement while awaiting admission to long-term care facilities, or respite care.

Summary Chart:

	TRI	CAMH	Baycrest	Whitby	
	Geriatric Psychiatry Service	Geriatric Mental Health Program	Behavioural Neurology Short Term in-patient unit (4 WEST)	Seniors Mental Health Unit	Seniors Memory Disorders Unit
Admission Criteria	Dementia diagnosis Related behavioral problems Medically stable Age > 65	Major mental illness/addiction + assoc. behavioral issues Medically stable Age > 60	Cognitive and behavioural problems due to brain disease Medically stable	>65 years of age medically stable severe/complex age related mental illness seniors with serious mental illness including refractory to treatment disorders	>65 years of age medically stable severe/complex age related mental ill clients with dementia, including effective management of challenging behaviours
Exclusion Criteria	Cannot be on forms under the Mental Health Act	Cannot manage medically unstable pts. No IV/tube feeds/O2/catheters		Not for permanent placement Interim placement while awaiting admission to LTCF Respite care	
Number of Beds	20	28 – Geriatric Admission Unit 20 – Geriatric Continuing Treatment Unit	20	50	
Admission Process	Application form Medical form Consults (Psychiatry, meds, blood work, imaging)	Completes referral form Medical referral not always required	Behavioural neurology application form CCAC form Letter from referring MD Consultation info (neurological reports/imaging)		
<i>When reviewed</i>	Weekly on Mondays + ad hoc	daily			
<i>Reviewers</i>	Psychiatrist, manager Member of team	Psychiatrist Inpatient manager	Director of behavioural neurology Nursing, social work		
Relationships Formal	None	Mt. Sinai ER Also used for medical clearance		Peterborough Regional Health Corporation service to Kawartha Lakes	

Informal	UHN – TWH short stay ER unit UHN outreach team	TWH/St.Joseph – medical clearance 30 LTCH for psychogeriatric consultation and support		<p>PASE provides community service (Psychiatric Assessment Services For the Elderly) WMHC-SMHP provides service, including PRC service, for LTCHs.</p> <p>Southlake Regional Health Centre Southlake provides Geriatric Mental Health Services to the community WMHC-SMHP provides service for LTCHs</p> <p>University of Toronto, Centre of Neurodegenerative Disease / University Health Network- Toronto</p> <p>Sunnybrook & Women's College Health Centre - Sunnybrook Residency Consultation Program</p>	
Referral Sources:	80% LTCH (Toronto, Peel, York Region) Outreach Team/PRC 20% Community: CCAC/hospitals/FMD	50% LTCH (downtown Toronto, south Etobicoke, East York, Peel Region) 50% Community: CCAC/hospitals FMD)			

APPENDIX 12

Toronto Police Service Contacts/ May 2006
COMMUNITY MOBILIZATION UNIT



CRIME PREVENTION and COMMUNITY RELATIONS

Headquarters:
7052

Fax: 416-80 8-

P.C. Mike DONNELLY (1589)	Crime Prevention Co-coordinator	416-808-7826	
Sgt. Janet Sullivan (2845)	Community Mobilization Unit	416-808-7293	

Divisional:

DIV.	CRIME PREVENTION	LOCAL	COMMUNITY RELATIONS	LOCAL
11	Russ GOLDING (3791)	416-808-1108	Russ GOLDING (3791)	416-808-1108
12	Jim LAMBE (3746)	416-808-1208	Jim LAMBE (3746)	416-808-1208
13	Denis CADORETTE (6939)	416-808-1387	John PIERREPONT (2157)	416-808-1308
14	Dave HAMMILL (3329)	416-808-1529	Jim McFEDRIES (7363)	416-808-1508
22	Al BENSON (6122)	416-808-2208	Kevin McALEER (2540)	416-808-2251
23	Robin Lynn HARVEY (7896)	416-808-2308	Bill MESSEL (7028)	416-808-2366
31	Phil HARRIS (3991)	416-808-3133	Tony McKENZIE (7257)	416-808-3108
32	Wayne PEIRCE (6541)	416-808-3256	Bill STEED (6752)	416-808-3208
33	Kelly DOWNIE (5535)	416-808-3395	Hugh BAGNALL (2958)	416-808-3325
41	Ian CAMERON (1228) Jill DAVEY (3965)	416-808-4127	Alan McDONALD (4394)	416-808-4108
42	Dave MANSFIELD (3011)	416-808-4220	Jack WIELD (7229)	416-808-4296
43	Gordon HAYFORD (4496)	416-808-4339	Dave GRAY (6836)	416-808-4321

DIV.	CRIME PREVENTION	LOCAL	COMMUNITY RELATIONS	LOCAL
51	Joseph SMITH (4475)	416-808-5187	Paul NADEAU (3879)	416-808-5108
52	Mark WILLIAMS (1308)	416-808-5208	Mike MOFFATT (6175)	416-808-5291
53	Richard LANGSTONE (6281)	416-808-5337	Larry STORTZ (5667)	416-808-5308
54	Gary POWELL (1142)	416-808-5429	Austin FERGUSON (7196)	416-808-5408
55	Robert McDONALD (7290)	416-808-5579	Vince HENDERSON (1342)	416-808-5508

Multilingual Community Interpreter Services (ON)
1185 Eglinton Avenue East, #605
Toronto, Ontario M3C 3C6
tel - 416 426 7051
fax - 416 426 7118
website - www.mcis.on.ca
contact: Latha Sukamar, E.D. of MCIS

Appendix 13A

MH/LTC System Advisory Group Terms of Reference

Background:

MH/LTC System Advisory Group would ensure the sustainability of the work of the LTC/MH Steering Committee, reviewing issues that arise over time and resolving them to ensure the needs of seniors with serious mental illness with related severe behavioural issues continue to be met.

Mandate:

To meet regularly to consider issues related to the needs of seniors with serious mental illness with related severe behavioural issues.

Objectives:

1. Provide a forum for all stakeholders involved with the care of seniors with serious mental illness and related severe behavioural response issues to meet to identify, investigate, and resolve issues impacting this population
2. Facilitate the development and strengthening of relationships between stakeholders
3. Continue to review and modify if required the alignment of LTCHs, and Outreach Teams and to meet the needs of LTCH senior residents with mental illness with related behavioural response issues
4. Review issues arising at the CCAC Advisory Group and the specialized Care Advisory Group
5. Identify and make recommendations to hospitals, community agencies, CCACs, LTCHs, PRCs, LHINs and the ministry regarding options for care for this population (e.g. barriers to care)
6. Provide advise on transition issues related to the ministry and the LHINs
7. Provide recommendations for continuing education needs

Membership:

Representatives from hospitals, LTCHs, PRCs, Geriatric Mental Health Outreach Teams, CCACs, and community agencies

Meeting Frequency:

Monthly

Advisory Group Support:

Support and coordination will rotate monthly between the LTCHs

Appendix 13B

Specialized Care Advisory Group Terms of Reference

Background:

Identified system gaps included LTCH residents experiencing difficulty accessing hospitals due to varying admission processes and eligibility/exclusion criteria (that appropriately reflect hospital expertise and/or mandate). However, there are no mechanisms for LTCHs and hospitals to discuss access issues.

Mandate:

The Specialized Care Advisory Group will meet regularly to consider issues related to admission and service coordination to hospitals with specialized programs serving Toronto.

Objectives:

1. Review applications/referrals for assessment and/or treatment to determine priority, and matching of senior's needs to care provided by a hospital.
2. Develop working relationships between the hospitals, outreach teams, PRCs and LTCHs Review the process for application to hospitals to coordinate, streamline and, as feasible, achieve consistency.
3. Make recommendations to the LTCH regarding alternate options for care while awaiting admission for the resident.
4. Provide feedback to the PRCs and outreach teams related to continuing education needs.
5. Review and make recommendations related to treatment plans for re-integration of LTCH residents to their LTCH.
6. Identify system gaps in service and develop recommendations to address these gaps, e.g. wait lists, wait times, number of refusals, LTCH 45 day psychiatric leave of absence.

Membership:

Representatives from each of the four hospitals with specialized programs, LTCHs, Geriatric Mental Health Outreach Teams and PRCs

Meeting Frequency:

Monthly

Advisory Group Support:

Group support and coordination would rotate monthly among the hospitals.

LTCH Resident Referral:

Case specific referral is the responsibility of the LTCH attending physician.

Appendix 13C

Wait List Review Advisory Group Terms of Reference

Background:

A senior is deemed eligible only if a management plan is in place so that the senior can be placed in the next available bed in the LTCH of her or his choice. CCACs require:

1. Assistance with determining the LTCH(s) that provides services and programs that best meets the needs of the residents.
2. On-going consultation related to the needs of seniors deemed eligible and awaiting LTCH placement in the community.

Mandate:

Review:

- the clinical needs of seniors (55 plus) who have been deemed eligible for placement in a LTCH and are awaiting placement, and demonstrate serious mental illness with related severe behavioural issues
- system/policy issues related to LTCH placement (e.g.: marketing, specialized units)

Objectives:

1. Assist in identifying the most appropriate LTCH setting to meet the needs of the senior on the LTCH wait list
2. As appropriate, consider and facilitate provision of in-depth assessment of the senior to determine the most appropriate setting to provide care
3. As appropriate, consider and facilitate the appropriate provision of treatment and care for the senior to:
 - transition effectively to a LTCH
 - remain at home while awaiting admission to a LTCH
 - continue living at home
4. Make recommendations to the CCAC regarding managing the needs of the individual while they are awaiting placement to maintain his or her highest level of functioning
5. Make recommendations and implement change related to the system and policies to enable effective CCAC functioning within the system

Membership:

One Advisory Group for each LHIN catchment area with representatives from CCACs, LTCHs (e.g.: LTCH director of care or administrator, geriatric mental health outreach Teams, hospitals, PRCs).

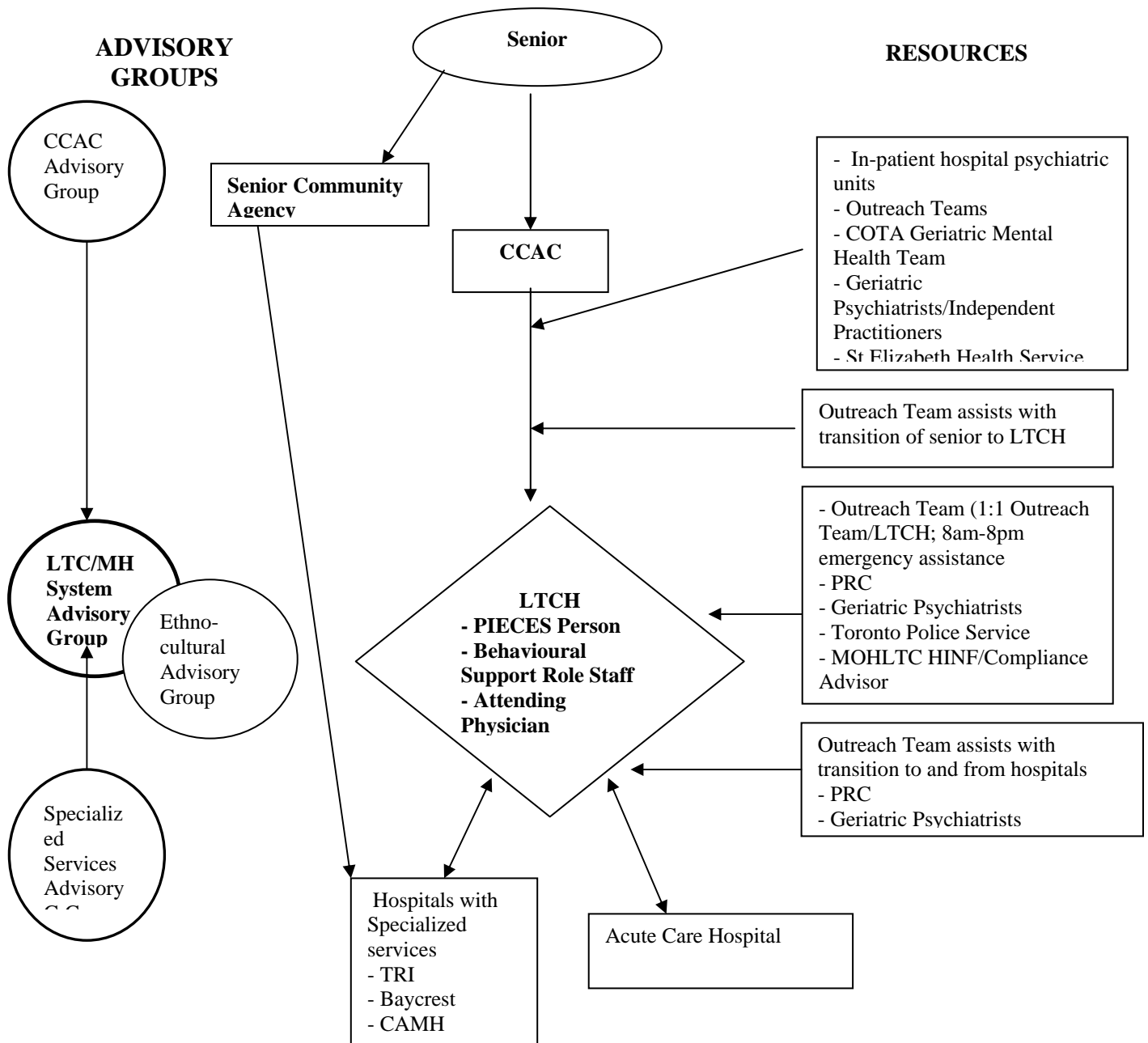
Meeting Frequency:

Monthly

Advisory Group Support:

Support and coordination provided by CCACs.

Appendix 14
Proposed Patient Flow Through the "System"



Appendix 15 Working Group Membership

Definition Working Group Members

Florence Wong, Yee Hong Centre for Geriatric Care - Chair
Elizabeth Lawson, Labdara Nursing Home
Dr. David Conn, Baycrest Centre for Geriatric Care
Dr. James Edney, Medical Director, Toronto Home for the Aged
Clara Tsang, Rouge Valley Health System
Sharon McIlveen, Rouge Valley Health System
Sue Chattha, Elm Grove Living Centre
Vania Sakelaris, MOHLTC

Inventory Working Group Members

Dr. Corrine Fischer, St Michael's Hospital - Chair
Ann Stephens, St. Michael's Hospital
Gaby Golea, CAMH
Janet McMullan, WMHC
Lynda Perry, PRCP
Margaret Buck, St. Elizabeth Health Service
Juliette Wood, Sunnybrook Health Science Centre
Janice Buchanan, MOHLTC

Stakeholder Role Development Members

Dr. Joel Sadavoy, Mt. Sinai Hospital - Chair
Dr. David Ryan, PRCP
Angela Robertson, Sistering
Penny Pashby, TRI
Carol Millar, Toronto CCAC
Jennifer Scott, North York CCAC
Gaby Golea, CAMH
Ann Stephens, SMH
Dr. Barbara Liu, Regional Geriatric Program
Dr. Corrine Fischer, SMH
Sally McMackin, UHN
Elaine Kuretzky, MOHLTC
Janice Buchanan, MOHLTC

Decision Tree Working Group

Dr. Benoit Mulsant, CAMH - Chair
Mary Nestor, Central Care Corporation
Elizabeth Lawson
Sally McMackin, UHN
Winnie Wong, Yee Hong Centre for Geriatric Care
Jennifer Scott, North York CCAC
Pat Hatton, PRCP
Lori Kane, MOHLTC
Vania Sakelaris, MOHLTC
Elaine Kuretzky, MOHLTC

Appendix 16

<u>ACRONYMS</u>	
ABI	Acquired Brain Injury
ACE	Advocacy Centre for Elderly
ADM	Assistant Deputy Minister
CAMH	Centre for Addiction and Mental Health
CCAC	Community Care Access Centre
CCSMH	Canadian Coalition for Seniors' Mental Health
CMI	Case Mix Index
CMU	Community Mobilization Unit
CONNEX	CONNEX Ontario Health Services Information operates the Drug and Alcohol Registry of Treatment (DART) the Ontario Problem Gambling Helpline (OPHG) and the Mental Health Services Information of Ontario (MHISO)
CPO	Crime Prevention Officer
CRO	Community Relations Officer
CSS	Community Support Services
DOC	Director of Care
DRC	Director of Resident Care
ED	Executive Director
EDP	Emotionally Disturbed People
EMS	Emergency Medical Services
ER	Emergency Room
FTE	Full Time Equivalent
GAU	Geriatric Admission Unit
GCTU	Geriatric Continuing Treatment Unit
GEM	Geriatric Emergency Management
HCA	Health Care Aide
HCCA	Health Care Consent Act
HFA	Home for the Aged
HIN	High Intensity Needs
HINF	High Intensity Needs Fund
LHIN	Local Health Integration Network
LTC	Long-Term Care
LTCH	Long-Term Care Home
MASA	Multicultural Alliance for Seniors and Aging
MCIS	Multicultural Interpreter Services
MCIS	Multilingual Community Interpreter Services
MD	Medical Doctor
MH	Mental Health
MOHLTC	Ministry of Health and Long-Term Care
MOL	Ministry of Labour
MOU	Memorandum of Understanding
MSW	Masters of Social Work
OANHSS	Ontario Association of Non-Profit Homes and Services for Seniors
OHSA	Occupational Health and Safety Act
OLTCA	Ontario Long-Term Care Association
OPGT	Office of Public Guardian and Trustee
OSAH	Ontario Safety Association and Health Care

ACRONYMS

OT	Occupational Therapist
PACE	Psychogeriatric Assessment, Consultation and Education
PC	Police Constable
PHIPPA	Personal Information Protection and Privacy Act
PIECES	A Psychogeriatric Guide and Training Program for Professionals in Long-Term Care Homes in Ontario
POW	Power of Attorney
PRC	Psychogeriatric Resource Consultant
PRCP	Psychogeriatric Resource Consultant Program
PSW	Personal Support Worker
QMP	Quality Management Program
RGP	Regional Geriatric Program
RN	Registered Nurse
RNAO	Registered Nurses' Association of Ontario
RPN	Registered Practical Nurse
RVHS	Rouge Valley Health System
SCU	Special Care Unit
SDM	Substitute Decision Maker
SHRTN	Seniors Health Research Transfer Network
SJHC	St. Joseph's Health Centre
SMH	St. Michael's Hospital
SW	Social Worker
TOR	Terms of Reference
TRI	Toronto Rehabilitation Institute
TSH	The Scarborough Hospital
TWH	Toronto Western Hospital
U-First	A Psychogeriatric Guide and Training Program for Non-Registered Staff in Long-Term Care Homes in Ontario
UHN	University Health Network
WMHC	Whitby Mental Health Centre
WSIB	Workers Safety and Insurance Board