

From Hospital to Home:

The Transitioning of Alternate Level of Care and Long-stay Mental Health Clients

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Main Messages

Good outcomes can be achieved for individuals with high complex mental health needs in the community when they receive the appropriate high support housing and community mental health services and supports. Community integration and meaningful contribution are reasonable goals.

Psychiatric ALC (*Alternate Level of Care*) days and *long-stay* days (defined here as days exceeding three months for a single hospitalization) consume a significant portion of all Ontario inpatient resources, representing 51% of all Ontario ALC/long-stay days. Further, individuals who have 90 days or more designated as ALC in acute care settings, or very long stays in tertiary facilities (i.e., six months or longer), have very complex conditions and needs. They are more likely to have schizophrenia or psychotic-spectrum illnesses, developmental disorders in addition to mental disorders (i.e., dual diagnosis), and co-occurring physical illnesses. The majority exhibit problematic behaviours and a large proportion have legal involvement.

Many hospital, high support housing, community mental health, long-term care, and dual diagnosis services are demonstrating innovative solutions to problems of transitioning ALC/long-stay clients and of providing access to residential and mental health services while working within existing budgets. Ontario has a wealth of collective knowledge to draw upon as it addresses this problem.

Discharge planning and transitioning processes are more successful when tailored to the needs of the individual, carefully planned, inclusive of family, appropriately timed, and collaborative in nature. A variety of “in-reach” and “out-reach” components between hospital and community providers can build better collaboration to support the transition process and find the right match between the client and the community placement.

Peer support plays a pivotal role in the transitioning process, both in preparing clients to leave hospital and in assisting their adaptation to the community. It should be viewed as integral to successful transitioning.

The important role of family in supporting the individual and acting as an ally to the transitioning process also needs to be respected by hospital and community mental health housing staff.

When hospitals provide their community partners with psychiatric back-up, streamlined access to readmission for clients, consultation, education and training, they instil confidence and trust and achieve higher receptivity to referrals of clients with complex mental health problems.

Client needs change over time and a full range of housing alternatives is required to accommodate the individual at different stages in the recovery process.

Access to high support housing and community mental health services and supports continue to be a serious problem due to long wait-lists and shortage of resources.

Access to high support housing (including both transitional and permanent housing, 24/7 supervision that is focused exclusively on the needs of complex ALC/long-stay mental health clients) needs to be increased to address the problem of long-stay clients in hospital. Funding should be sufficient to provide appropriate levels of and mix of staffing (e.g. personal support workers) and to enable such housing to achieve the characteristics for model high support housing. High support housing needs to be embedded in a full continuum of housing alternatives to achieve greatest effect.

A mechanism is needed for the administration of flexible funds that follow the client for the purpose of purchasing needed services and supports to facilitate discharge planning and transitioning. Earmarking these funds for smaller, time-limited items (e.g., transportation, medications) is viewed as the optimal approach. In addition, allowance of greater flexibility in the use of mental health program funds would enable programs to shift funds to where they would provide the most benefit.

Standard community mental health services, ACT, and case management are not equipped to manage the special problems presented by those with very high needs. Services need to be adapted for this clientele in general and, more specifically, for geriatric clients, those with concurrent substance use and mental disorders, and those with dual diagnosis.

Enhanced policy integration at the inter-ministerial level (i.e., MOHLTC and MCSS) and intra-ministerial level (e.g., mental health and addictions, or mental health and seniors) would facilitate more seamless care, and prevent clients from getting lost in the system.

System-wide data are available to monitor volume of ALC/long-stay clients in hospital and to measure tenure in the community after discharge.

Executive Summary

In March 2009, the MOHLTC requested the assistance of the Health Systems Research and Consulting Unit (HSRCU), CAMH, in undertaking an analysis of the ALC/long-stay mental health clients in acute and tertiary care facilities. The Ontario Mental Health Foundation administered the funds for the project. The primary aims of the project were to identify their clinical characteristics and the housing and community mental health services and supports required for transitioning them to the community.

Findings from earlier mental health system planning studies in the province (i.e., the *Comprehensive Assessment Projects*, or CAPS, conducted 1998-2002; Koegl et al., 2004) suggested that 40% of current tertiary care psychiatric inpatients with severe and complex needs could be served in the community with the appropriate housing, services and supports in place. Since that time, the discharge of ALC/long-stay individuals with mental health problems has been a priority for acute care and tertiary providers. The current policy environment of the MOHLTC also places a strong focus on ALC and long-stay clients (*Appropriate level of care: a patient flow, system integration, capacity solution*, 2006).

To address the project's first objective of determining the extent and characteristics of inpatients designated ALC/long-stay, a secondary analysis was conducted of data available from standardized inpatient assessments. The *Resident Assessment Instrument-Mental Health* (RAI-MH; Hirdes et al., 2000-01; Hirdes et al., 2002) is mandated for all people in designated psychiatric beds in Ontario, thus providing detailed system-wide information on both current and discharged inpatients. The ALC designation, which has been in use in the acute care hospital system for some time, has been recently incorporated into the RAI-MH such that this information is now also a reporting requirement for tertiary hospitals.

The project's second objective was to obtain Ontario stakeholder feedback on ALC/long-stay patient groups thought to benefit from high support housing, including individuals with dual diagnosis, concurrent disorders, and geriatric mental health issues. Focus was placed on identifying clinical, behavioural, and functional support needs, discharge barriers, and transition challenges. Thirdly, the project sought to identify selected Ontario residential treatment/high support housing initiatives and to describe existing models and strategies for increasing capacity in the sector.

Multiple methods were used to collect data: five provincial focus groups conducted with acute and tertiary hospital representatives, community residential and mental health service providers, and MCSS, MOHLTC, LHIN, and CCAC representatives; nine key informant interviews with experts in various domains, geriatric mental health, dual diagnosis, residential and community mental health, acute care and LHIN management; two surveys administered to collect in-depth information on high support housing and lessons learned from the MCSS specialized residential accommodation program; a literature scan of published and grey literature; and secondary data analysis of provincial administrative databases.

Results from the secondary data analysis indicate that ALC/long-stay days in psychiatric care settings are large in number. They consume a significant portion of all Ontario inpatient

resources, accounting for nearly 51% of all ALC/long-stay days in Ontario. Of particular interest are inpatients with lengthy ALC terms (i.e., more than 90 days designated as ALC in a single hospitalization) or with extremely long stays in hospital (i.e., six months or longer), as they are using significant bed resources and thought to benefit from high support housing. These long stays block beds in both acute and tertiary hospitals. In acute care hospitals, 60% of ALC stays in designated mental health beds are lengthy according to the above definition. In tertiary care hospitals, this figure is 65%.

Analyses indicate that these patients are impaired by multiple complex health and social issues that can be expected to contribute to difficulties in adapting to community living. Compared to those without ALC days, they are more likely to have psychotic disorders, including schizophrenia, dual diagnosis, and co-occurring physical illnesses. Many also have co-occurring substance use disorders, although such diagnoses did not differentiate them from other patients without ALC days or with shorter stays.

What we have gained with this project overall is a “big picture” of the scope of the problem, including who are the clients, what effective transitioning strategies are being used, and what needs to be done. We found great commonality in the following challenges identified by participants: the shortage of model high support housing; limited supply of community mental health services; low accessibility to primary care and psychiatric follow-up; need for improvements in assessment, discharge planning and referral processes; and coordination challenges. Our findings resonate with previous investigations into ALC issues and problems (*Appropriate level of care: a patient flow, system integration, capacity solution, 2006*).

We found high levels of creativity, commitment, and innovation across the province. Many excellent examples of system collaboration were identified, both cross-sectoral and cross-service (i.e., hospital and community mental health), and we applaud those efforts. A broad range of approaches and strategies is being used, leading us to acknowledge that there is no one solution to solve the problem of ALC/long-stay mental health clients. Many of these local solutions are a function of particular relationships and resources and not necessarily templates for the province as a whole.

We conclude with the point that only an integrated, “whole system” approach is sufficient to deal with the multi-dimensional nature of the ALC/long-stay problem. Implications of the present work highlight a range of interventions and strategies that, if implemented, may be expected to decrease mental health ALC/long-stay days. They reflect a combination of approaches that could be developed within existing resources and with additional resources. This is consistent with the Expert Panel’s conclusion that reduction of ALC days will require significant investments and improved integration (*Appropriate level of care: a patient flow, system integration, capacity solution, 2006*). To ensure the delivery of timely, seamless, and appropriate services for individuals with psychiatric disorders, therefore, ALC days and lengthy stays in hospital are important areas to address.

From Hospital to Home: The Transitioning of ALC, Long-stay Mental Health Clients

I Introduction and Background

The Ministry of Health and Long-term Care (MOHLTC) has identified the need for increased information and understanding of residential treatment/high support housing¹ as a service option for people with severe and complex mental health problems, especially those who are currently receiving inpatient services. In March 2009, it requested the assistance of the Health Systems Research and Consulting Unit (HSRCU), CAMH, in undertaking an analysis of the ALC/long-stay mental health clients in acute and tertiary care facilities. The primary aims of the project were to identify their clinical characteristics and the housing and community mental health services and supports required for transitioning them to the community.

The term ALC, which stands for *Alternate Level of Care*,² is used generally by the health care system to describe patients who are waiting for a more appropriate level of care to meet their needs. The idea is that the hospital bed is being occupied by an individual who no longer needs service in that setting and who is using limited, expensive resources while waiting to be discharged to a more appropriate setting.

In addition to the formal ALC designation, some mental health patients with long tenures in hospital not formally designated as ALC are nonetheless thought to have the potential to move into the community with the right supports. For example, findings from earlier mental health system planning studies in the province (i.e., the *Comprehensive Assessment Projects*, or CAPS, conducted 1998-2002; Koegl et al., 2004) suggested that 40% of current tertiary care psychiatric inpatients with severe and complex needs could be served in the community with the appropriate housing, services and supports in place. Studies in other jurisdictions also describe the need for highly staffed, rehabilitation-oriented residential care and the population that may benefit from it (Gudeman & Shore, 1984; Lesage et al., 2003; Trauer et al., 2001).

In Ontario, the CAP findings were widely endorsed by mental health stakeholders, but at the time there was little to no capacity to deliver high support housing in the system. Recently, there have been some efforts to create residential treatment capacity in the mental health sector (e.g., the *Alternate Milieu* units at CAMH). Other related initiatives have taken place in the developmental sector for individuals with both developmental disability and mental health issues (i.e., dual diagnosis), such as the specialized treatment beds coordinated through the Community Networks of Specialized Care.

¹ The term high support housing is the contemporary term and is replacing the term residential treatment in all sections of the report except for the literature scan.

² Ontario ALC definition: “when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting, the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate” (<http://www.longwoods.com/product.php?productid=20910>, July, 2009).

Since the time of the CAP studies, a standardized inpatient assessment, the *Resident Assessment Instrument-Mental Health* (RAI-MH; Hirdes et al, 2000-01; Hirdes et al., 2002), has been mandated for all people in designated psychiatric beds in Ontario, thus providing detailed system-wide information on both current and discharged inpatients. The ALC designation, which has been in use in the acute care hospital system for some time, has recently been incorporated into the RAI-MH such that this information is now also a reporting requirement for tertiary hospitals.

The discharge of ALC/long-stay clients has been a priority for acute care and tertiary settings. The current policy environment has placed a strong focus on ALC and long-stay clients. In 2006, the provincial Expert Panel on Alternate Level of Care produced a report that outlined an ALC action plan and implementation recommendations to improve system performance and decrease ALC days (*Appropriate level of care: a patient flow, system integration, capacity solution, 2006*). While the Expert Panel's focus was primarily on seniors, many of the findings and recommendations can be generalized to apply to this project. In October 2007, the Ontario Premier announced that reducing wait-times was one of the government's two top priorities and the project Wait Times Information Strategy (WTIS) was launched. The purpose of the WTIS is to gather information on current ALC processes and data collection.

Through these and other means ALC/long-stay clients have been identified as a cause of bed shortages within the mental health system. This is an urgent problem and its resolution is critical if hospitals, with decreasing bed numbers, are to serve new people, and if the mental health reform aim of serving persons in the least restrictive setting is to be better realized.

The objectives of this project were threefold:

1. Determine the numbers of inpatients designated as ALC/long-stay and generate patient profiles using RAI-MH and other provincial administrative data.
2. Obtain Ontario stakeholder feedback on ALC/long-stay patient groups thought to benefit from high support housing, including individuals with dual diagnosis, concurrent disorders, and geriatric mental health issues. Focus is placed on identifying clinical, behavioural, and functional support needs, discharge barriers, and transition challenges.
3. Identify selected Ontario residential treatment/high support housing initiatives and describe existing models and strategies for increasing capacity in the sector.

II Methods

Project Advisory Panels:

Phase 1 and Phase 2 project advisory panels were struck to guide the project team at different stages (see Appendix A). The Phase 1 panel provided feedback on the elements of RAI-MH that were most pertinent to the population under study. Participants in the Phase 2 panel were

selected for their expertise and knowledge of particular sectors, including acute, tertiary, and community care, and/or relevant sub-populations represented in the project (i.e., dual diagnosis, concurrent disorders, and geriatric mental health clients). In addition, both the MOHLTC and MCSS were represented. The Phase 2 panel provided input at two different stages of the project. Panel members also provided feedback on a draft version of the final report.

Literature Scan:

The purpose of the literature scan was to: provide an overview of the outcomes surrounding the transitioning of long-stay mental health clients from hospital to community, as well as insight on relevant strategies and processes used in transitioning and information about the characteristics of high support housing and related community supports needed to maintain this population in the community. In addition, the literature on the special needs and challenges pertaining to three important sub-populations was touched on: individuals with concurrent disorders, dual diagnoses and people with geriatric mental health issues. The project team canvassed a broad range of published and grey literature pertaining to these areas.

Secondary Data Analysis:

An analysis of provincial administrative data on service use and clinical characteristics was undertaken for clients who were designated ALC and/or long-stay (see Appendix D for details). The analyses generated patient profiles relevant for determining need for high support housing. The profile content areas were determined in collaboration with the Phase 1 project advisory panel, discussed above.

Focus Groups:

Five focus groups were held in the communities of London (n=13), Hamilton (n=18), Kingston (n=15), Ottawa (n=17), Sault Ste. Marie (n=21). A total of 84 people participated in the focus groups representing perspectives from the LHIN's, MOHLTC, MCSS, CCAC's, supported housing, community mental health and addictions, and those working in acute and tertiary care hospitals. The Ottawa meeting was held for those working with people with dual diagnosis. The purpose of the focus groups was twofold. Each group received the client profile based on the RAI-MH data analysis and participants were asked to provide feedback on the findings. Subsequently, a series of questions were used to guide discussion of barriers to discharge, transitioning strategies and processes, and residential treatment were asked. Each group was facilitated by the project lead and lasted approximately four hours. Written summaries were then compiled by the project coordinator.

Key Informant Interviews:

Key informant interviews were conducted with individuals identified as having relevant supplemental information for the project (see Appendix B). The intent was to gain further insight into the mental health sector's housing and community services system's capacity to manage people with complex, serious mental health problems in the community. The needs of specific

sub-populations and more in-depth knowledge of ALC patients in acute care were additional topics highlighted for discussion.

Surveys:

The project administered two surveys to capture more detailed information on: 1) the characteristics of the high support housing identified by focus group participants and 2) the lessons learned from the dual diagnosis treatment beds specialized accommodation program.

III Literature Scan

Four broad areas of literature were summarized to provide context on current issues related to ALC and long-stay clients in Ontario:

- Description of the population in need of residential treatment
- Transition processes and strategies
- Characteristics of residential treatment and community supports
- Outcomes from large studies of psychiatric hospital closures

The bulk of this scan comes from the literature on tertiary facilities as we found scant formal literature pertaining to ALC mental health clients in acute care facilities. As previously noted, the term *high support housing* replaces *residential treatment* in all sections of the report except for the literature scan, in order to best reflect the language used in the field.

1. Profile of the Population in Need of Residential Treatment

The deinstitutionalization literature describes a unique subgroup of patients in psychiatric facilities who have difficulty being successfully discharged. Identified as patients that come from long-stay populations who were discharged and then readmitted (Leff et al., 1996), or as groups of patients who are the last to leave a psychiatric hospital at the end of a closure program, these individuals have been referred to “difficult to place”, and are characterized by severe and persistent disabilities. Despite their numerous challenges, there is a paucity of information describing these individuals and the specific problems that make them difficult to successfully relocate to the community.

From the information that exists, we know that severe and persistent mental illness is common within this group. Sheppard (1995) characterizes long-stay patients as falling into three distinct subgroups, all with severe psychiatric and behavioural problems: young males with schizophrenia (majority of cases); older, mostly female patients with a diagnosis of affective psychosis; and those with organic brain syndromes and associated behavioural problems. Newton et al. (2000) also provides a profile of long-stay patients describing the typical patient as presenting with ongoing delusions and other psychotic symptoms on a periodical basis. Additional work identifies active symptoms of schizophrenia and bipolar disorder as highly prevalent (Trauer et al., 2001; Davis et al., 2006; Johnson et al., 2009; de Girolamo et al., 2002).

While studies have been able to identify patterns of more severe diagnoses, it is not uncommon for patients to present with additional psychiatric issues and symptoms, making them especially difficult to place (Hallam & Trieman, 2001). The presence of multiple disabilities is found in other research, where it has been shown that high percentages of epilepsy, brain damage, sensory deficits, and neurological disorders exist among long-stay mental health clients (Wing & Furlong, 1986; Sheppard, 1995; Trauer et al., 2001). Adding to the complexity, studies have also shown that a large number of long-stay patients have co-morbid physical disabilities and/or medical problems (Trainor & Ilves, 1999).

Due to their characteristically complex symptomatology, it can be quite difficult to place these patients in a community setting. This is further complicated by the fact that long-stay patients tend to display a range of challenging and disruptive behaviours (Hallam & Trieman, 2001). More specifically, Hallam and Trieman (2001) report that aggressiveness, non-compliance with medication and inappropriate sexual behaviour were the most common problem behaviours among this group of individuals. Physical aggression and hostility have also been identified in a group of long-stay patients who were examined within a psychiatric facility in the UK (Leff et al., 1996). Newton et al. 2000 also found that abusive and anti-social or unacceptable behaviour was prevalent among long-stay patients, adding also suicidal ideation and risk harm to others as issues within this group. Other problem behaviours thought to prevent successful discharge include poor motivation, poor self-management, and poor role performance capacities (Wing & Furlong, 1986).

A further defining characteristic among long-stay mental health clients is a high level of dependency. Becoming “institutionalized” is a common result of a lengthy stay, which forces inpatients to rely on both hospital staff and services and prevents them from assuming more responsibility for themselves. As a result, these individuals typically lack social support networks of their own. Wing and Furlong (1986) showed evidence that long-stay clients often have long histories of hospital admissions and few roots in the outside community, including a lack of employment history, significant partners, or families who accept and advocate for them.

There is a robust literature providing information on the characteristics of long-stay tertiary patients, compared to the scant literature on “difficult to discharge” individuals in acute care facilities. Two recent studies show that the characteristics of long-stay acute care patients closely resemble those in tertiary facilities. The first study, conducted in Italy, obtained comprehensive nation-wide data on the functioning of public and private inpatient facilities and examined the characteristics of patients who had been hospitalized for more than three months (Gigantesco et al., 2009). Most such patients were diagnosed with either schizophrenia or mood disorders, and their average length stay was approximately six months.

Another study of patients at a 250-bed acute care hospital demonstrated that scores on the Brief Psychiatric Rating Scale (BPRS-A) obtained at admission were strongly associated with whether a patient was discharged into the community or transferred for extended care (Hopko et al., 2001). Of note, those transferred for extended care had higher scores on subscales pertaining to resistance and positive symptoms, whereas those with higher scores on psychological discomfort were more likely to be transferred to the community. Discharge status also differed as a function of gender, ethnicity, employment history, and marital status. Specifically, single patients were

more likely to be transferred for extended stays, whereas those who were married, divorced, or separated were more likely to be discharged to the community (Hopko et al., 2001). Gigantesco et al. (2009) further described the long stay population in acute care facilities as middle-aged, unemployed, and living with either a partner or family member.

While functional impairment can be handled within residential care, the co-occurrence of undesirable behaviours makes community placement particularly difficult for these individuals. As in tertiary care, long-stay acute care patients are characterised as more violent, exhibiting more anti-social behaviours, and as having a lack of social supports and poor psychosocial functioning (Gigantesco et al., 2009). Specifically, 40% of patients were identified as being at risk for anti-social and other dangerous behaviours, and one-third were without close relationships or social support. Long hospital stays exacerbate the problems of poor daily living skills and weak social networks.

2. Transition Processes and Strategies

Given the complexity of long-stay patients, it has repeatedly been noted that discharge to Residential Treatment Facilities (RTF's) can be a challenge. As such, transitioning these clients from an inpatient unit to a community facility is a process that should be thoughtfully planned out well before discharge. The literature offers some suggestions to increase the likelihood of success.

First, the discharge process should begin at admission. That is, at admission, discussions should begin regarding health and social support needs and appropriate living arrangements upon discharge. This enables providers and patients to explore community options early on in the stay. Further, a collaborative discharge planning process involving all the necessary players, including the client, is most effective. Involving relevant individuals and stakeholders well ahead of discharge is necessary to facilitate a seamless process (Watts et al., 2000).

A good example of this collaborative effort is provided by McGrew et al. (1999), who describes how a transition committee composed of a variety of stakeholders met regularly to discuss the transfer plan for each patient in detail. This group also planned services and assisted with physically transporting the client to the community. A second study also described how, prior to discharge, a multidisciplinary group of specialists met regularly to discuss the resettlement process (Bhaumik et al., 2009). In line with these findings, stakeholders involved in the discharge process should presumably agree with the methodology used to understand the client's needs and link him or her to appropriate treatment options (Holley et al., 1997).

Another example was cited in a collaborative position paper prepared by the Ontario Hospital Association (OHA), Ontario Association of Community Care Access Centers (OACCAS), the Ontario Association of Non-profit Homes and Services for Seniors (OANHSS), and Ontario Long-term Association (OLTCA). This paper described how a multi-stakeholder ALC working group was created to develop practical solutions and system strategies to address ALC patients. Other strategies that have been implemented at the hospital level include the establishment of dedicated ALC beds, education programs for families and patients, and implementation of patient flow policies by the OACCAC.

It is also important to establish pre-discharge lines of communication between the hospital and the community, as well as to explain the needs of the patient to the receiving agency and ensure that appropriate supports are in place. Generally, establishing a strong partnership between hospital and community is necessary to ensure that linkages with the necessary resources and individuals continue after discharge. Ultimately, additional effort and careful planning at this stage will be beneficial to the client by making them feel at ease, thereby reducing the likelihood of returning to hospital.

Involving the community agency early on also allows the client to feel more comfortable with the process, as the agency can become more attuned to his or her needs. As long-stay clients have often been institutionalized for a number of years, they are likely to feel overwhelmed and pressured to re-adjust quickly to the outside world (i.e. learn new skills and establish social support networks). It is important to minimize this stress by allowing time for them to adjust and establish the appropriate supports early on. To assist with this, it is important that essential services (including inpatient services and adequate supervision) are transferred from hospital staff to support workers in the community. In one study, the staff even transferred with the patients from hospital to the community to help manage symptoms and prevent deterioration of their mental state (Hobbs et al., 2002). Further, patients who were friends were often transferred to the same community residence.

In spite of the many challenges, research shows that many “difficult to discharge” inpatients can be successfully served in the community (Trainor & Ilves, 1999; Mc Gonagle, 2002; Hallam & Trieman, 2001; Trauer et al., 2001). Hobbs et al. (2002) reported that a 24-hour staff supervised setting was necessary to assist residents in coping with the community transition. In some cases, community staff visited the patient while in the hospital to discuss plans for the future (McGrew et al., 1999). Collaboration between the necessary support services is essential to meet the needs of these individuals.

3. Characteristics of Residential Treatment and Community Supports

As noted previously, the literature suggests that RTF’s are an appropriate solution for individuals with severe and persistent disabilities (McGonagle, 2002; Hallam & Trieman, 2001; Trainor & Ilves 1999; Trauer et al. 2001). In a recent provincial planning study (Koegl et al., 2004), residential treatment was recommended for individuals who were psychiatrically stable and did not need ongoing tertiary inpatient care, but who still required a high level of support in a structured setting. Within tertiary care hospitals, it was suggested that residential treatment would be appropriate for about 40% of inpatients who could be discharged if this support was available in the community. Studies in other jurisdictions also describe the need for highly staffed, rehabilitation oriented residential care for the same population (Gudeman and Shore, 1984; Lesage et al., 2003; Trauer et al., 2001; Trieman et al., 2009).

While a clear definition of RTF’s has not been established (Trainor & Ilves, 1999), they are broadly conceptualized as offering both housing and a treatment program. In his review of RTF’s in England, Trainor identified long-term structured residences for people who require treatment and rehabilitation in a secure setting. These should be a secure lockable facility for up to 16 residents and have the capability of dealing with severe behaviours such as fire setting. Another

type of residential treatment for less disabled clients is a transitional facility where residents are involved in the community and may be receiving intensive support, such as ACT (Trainor & Ilves, 1999).

Within Canada, the US and UK, there are a number of examples of successful RTF-like programs. For example, Seven-Oaks, located in Victoria BC, is a 12-bed RTF that accepts residents who have delusions, psychosis and socially unacceptable behaviours. The majority of these individuals have been in hospital for most of their lives. RTF's were also built to accommodate long-stay patients discharged from Riverview Psychiatric Hospital, also formerly in BC.

From the RTF literature, certain defining characteristics have also been identified that are consistent with mental health reform emphasis on individualized approaches, community integration, and recovery (Community Support and Research Unit [CSRU], 2009; Davis et al., 2006). This is evident by the way the literature describes the physical aspects of such facilities. Specifically, they should foster social interaction by having common kitchen and living areas, and provide opportunities for recreational activities and skill development in multiple domains, including cooking, performing household chores and grocery shopping, and using public transportation (Holley et al., 1997). The facilities should be non-institutional, offering homelike conditions with separate rooms and congregate living spaces and allowing clients to personalize their living space (Trainor & Ilves, 1999). Finally, they should be defined by flexible security features (e.g., unbreakable glass, removal of electrical outlets, velcro curtains) and risk management controls, along with staff supervision and support.

The services and supports provided in RTF's should promote autonomy and peer support, in order to facilitate client satisfaction and community adjustment (Trainor & Ilves, 1999). Clients should be helped to access a range of services, including the requisite mental health services, social services, educational programs, community services, and other services provided by community agencies.

Continuing with this theme of integration, various authors recommend that programming reflect recovery-oriented, client-centred principles, and meaningful activity, including community involvement and up to daily access to skills training and structured group treatment (Trainor & Ilves, 1999). Individualized supports and supportive counselling are emphasized as important elements, along with psychosocial rehabilitation and psychiatric treatment. It is noted that the integration of existing community mental health services to promote independence and self-sufficiency is important (Trainor & Ilves, 1999; Holley et al., 1997).

Another common theme involves having a multi-faceted and flexible approach to programming and staff supports (Hobbs et al., 2000). Residential options and programming should be flexible, ranging from one-on-one assistance for basic living skills to planning for more independent living (Hobbs et al., 2000; Holley et al., 1997; McGrew et al., 1999).

A multidisciplinary range of highly trained mental health staff is recommended, including nurse practitioners, occupational therapists, social workers, recreation therapists, and personal support workers, who provide various kinds of treatment, support, psychosocial rehabilitation, and

facilitate peer-support initiatives. Staff need special skills in crisis intervention and behavioural management in order to deal with severe aggression and other problem behaviours. Housing support workers are needed to provide 24/7 support and supervision (Koegl et al., 2004; CSRU, 2009). Staff ratios are quite high, ranging from 1:5 to exceeding 1:1 in some cases. Security, staffing level and support workers' skills should be aligned with the intended clientele (Trainor & Ilves, 1999; CSRU, 2009).

Many authors refer to the importance of having a full continuum of housing alternatives, from transitional and long-term RTF's to a variety of more independent living arrangements where clients have their own self-contained apartments and access to external supports (CSRU, 2009). The housing continuum allows residents to transition from larger group homes to smaller more independent accommodations as appropriate (McGrew et al., 1999; Hobbs et al., 2000; Hobbs et al., 2002). It also needs to be recognized that some clients will need long-term housing stability and possibly a "home for life" (Trudel & Lesage, 2006). Ongoing evaluation and system monitoring are recommended to ensure that gaps in the continuum are identified and filled to enable the continuation of the client's transitioning process.

4. Outcomes from Large Studies of Psychiatric Hospital Closures

The widespread closure of psychiatric hospitals has enabled researchers in several jurisdictions to examine the short and long-term impact of transitioning inpatients to residential treatment settings in the community. Several studies have traced the progress of the "difficult to discharge" patient across multiple domains, covering symptom profiles, level of functioning, and quality of life. In the UK, the *Team for the Assessment of Psychiatric Services* (TAPS) project was carried out by a multidisciplinary group of researchers who evaluated the closure process of two English psychiatric hospitals. They followed the progress of the 670 residents who were placed in the community (Leff et al., 1996). Similarly, an amalgamation of two psychiatric facilities in Sydney, Australia formed the basis of an examination of the clinical progress of 40 patients discharged to the community (Hobbs et al., 2000; Hobbs et al., 2002). Additional longitudinal studies from the US, UK, and Australia assess outcomes of residents post-discharge and are included in this review.

Client *Quality of Life* (QOL) was one area where most studies found improvements post-discharge. Studies of residential treatment programs have shown that residents continually rate their QOL as higher than when they were in a hospital setting (de Girolamo & Bassi, 2004; Trauer et al., 2001). Specifically, Ehlert & Griffiths (1996) found that, compared to inpatients, residents in residential treatment generally had more access to amenities, more control over their daily lives, more personal belongings and more privacy. Trauer et al. (2001) also found that most relatives and caregivers preferred these settings to inpatient units for their family members. Findings related to tenure are mixed, and it is unclear whether residents move onto more independent housing. Hallam & Trieman (2001) demonstrated that a good portion of residents did transition to a more independent environment, while others found that the majority of occupants remained in a high support facility over the first five years (de Girolamo & Bassi, 2004).

Hobbs et al. (2000) also demonstrated improvements in QOL for long-stay patients transferred to the community at both two-year and six-year follow ups. In this case, QOL was identified by general satisfaction with their lives and themselves. Freedom and independence were cited as the features residents valued most about their new surroundings. This was echoed by Trauer et al. (2001) in an examination of long-stay patients transferred to a Community Care Unit (CCU). Similarly, a study examining the clinical progress of long-stay patients discharged from a State Hospital in the US reported improvements in QOL post-discharge (McGrew et al., 1999). The literature suggests that QOL ratings are dependent on age and history of psychiatric illness. Residential treatment settings have also been associated with a reduction in behavioural difficulties when compared to a hospital setting. Two separate studies conducted longitudinal evaluations of RTF's and found that aggression decreased by half when consumers were discharged into an RTF from an inpatient setting (Hallam & Trieman, 2001; Trauer et al., 2001).

The above studies also found improvement in residents' life skills. For example, Leff et al. (1996) showed that residents progressed in a variety of everyday tasks, such as budgeting personal finances, using public transportation, grocery shopping, and cooking and other household chores. This finding was highlighted in another study, showing that residential treatment improved residents' domestic skills, self-care, and community skills (de Girolamo & Bassi, 2004; Hallam & Trieman, 2001). Another study showed similar progress in life skills at a two-year follow-up, which remained stable at six-years. The study further suggested that psychiatric history, lengthier pre-discharge periods, and level of education had an impact on the proficiency of daily tasks (Hobbs et al., 2000).

The transitioning process within the community continues over time. Benefits of a lengthy integration process may be seen in decreases in level of care and decreasing need for staff supervision. Hobbs et al. (2002) describe the changes in resident living accommodations six years post-discharge, where a majority of residents were able to move from larger 10-person homes to smaller 2-to-3-person accommodations. Further, staff supervision decreased from 24 to 8 hours per day. At follow up, 36% of these residents were living semi-independently and receiving minimal supervision.

While these studies demonstrate that life skills and social behaviours improve when residents are transferred to community-based treatment facilities, the findings are less clear around social outcomes. For example, one study found little improvement in the amount of social activity between inpatients and residents of RTF's (Ehlert & Griffiths, 1996). Another study showed the amount of social contact in the community did not differ significantly from that in hospital at a one-year follow-up (Trauer et al., 2001). The TAPS project also assessed a resident's social behaviour according to the quantity and quality of their social interactions. Results demonstrated an increase in the number of individuals that residents considered as friends, although the actual size of their networks did not change. A further study, showed that RTFs facilitated a positive increase in satisfaction with co-residents and the development of friendships (de Girolamo & Bassi, 2004; Trauer et al., 2001); however it has been noted that this increase in connections was predominately with family and through mental health services (Hobbs et al., 2002; Trauer et al., 2001).

Outcomes for clinical symptoms are less positive as well. For example, a number of studies found no change in residents' mental health status between discharge and follow-up (de Girolamo & Bassi, 2004; Hallam & Trieman, 2001; Trauer et al., 2001). Hobbs et al. (2000) found only a slight reduction in psychiatric symptoms two years post-discharge. Though this finding was not significant, clinical symptoms remained stable four years later. The TAPS project also examined outcomes after five years and, again, clinical symptoms, particularly delusions and hallucinations, remained stable over time (Leff et al., 1996; Leff & Trieman, 2000). This study, found that 10% of those who transferred to the community had to be re-hospitalized. The authors suggest that 9 to 10 beds be provided for every 100 long-stay patients who have been discharged.

Trauer et al. (2001) showed no change in positive and negative symptoms, assessed using the Positive and Negative Syndrome Scale (PANSS), or in disability one-year post-discharge. A further study also demonstrated stability of clinical symptoms at follow up (McGrew et al., 1999). While clinical symptoms do not appear to decrease, it is important to note that residents did not deteriorate. Two separate studies have shown that residing in an RTF decreases the need for hospital stays over time (Trauer et al., 2001; Anthony et al., 1999). Further, the deinstitutionalization of large numbers of long-stay mental health patients did not result in significant homelessness or incarceration (Rothbard et al., 2007).

Despite residents being hesitant about discharge from hospitals, a majority of individuals who took part in this transitioning process reported that they preferred to remain in the community (Leff et al., 1996; Trieman et al., 1999; Kincheloe, 2007; Braun et al., 1981; Barry & Crosby, 1996; Trauer et al., 2001). This sentiment was reinforced by family members. At one-year post-discharge, results demonstrated that residents experienced more independence and greater satisfaction with their privacy, as well as the amount of rehabilitation they received, their physical setting, and their life circumstances when receiving treatment in the community (Trauer et al., 2001).

Research demonstrates that most residents are capable of maintaining or improving their level of functioning while receiving treatment in the community. Improvement in life skills and social networks are noted for the majority of residents, and it seems that community-based treatment can provide individuals with the opportunity for a more "normalized" lifestyle. Though progress with clinical symptoms is not apparent, it was suggested that perhaps a longer follow-up time is necessary to detect major changes (Trauer et al., 2001). Success of treatment within the community depends on a number of variables, including psychiatric history, social support, and length of discharge period. Level of proficiency of daily tasks and socio-economic factors also play a role in determining outcomes for these clients.

Residential treatment has also been suggested to be more cost-effective. For example, inpatient care in Ontario costs \$500-\$800/day for each bed. At CAMH in Toronto, it is estimated that the cost per bed is \$579/day, while the cost elsewhere is estimated at \$250 to \$300 for non-secure facilities and \$350 to \$400 for secure facilities. Additional research has also demonstrated costs savings in utilizing RTF's as an alternative to inpatient care (Anthony et al., 1999; Garrod & Vick, 1999; Trieman et al., 2009).

In sum, there are a group of long-stay patients who are stable but still require an intensive form of care and support to live successfully in the community. Studies have shown that there is no significant clinical benefit to keeping them as inpatients, yet due to the complex nature of their illness, they are very difficult to discharge. RTF's, providing high levels of support, supervision and rehabilitation, are demonstrated to be beneficial for this group.

IV Findings

1. Secondary data analysis of ALC/long-stay in Ontario

The objectives of this analysis were to assess the overall prevalence of ALC days and long hospital stays in designated psychiatric beds in Ontario, to identify patient-level factors associated with ALC/long-stays, and to consider the discharge resources and post-discharge outcomes of such patients. The primary data source is RAI-MH records from fiscal year 2007-08. The analysis excluded individuals with dementia, as the needs of this subgroup are not the focus of this project (see Appendix D for more details on the analysis). The findings are first briefly summarized, followed by more detailed summaries below.

Our results indicate that ALC/long-stay days in psychiatric care settings are highly prevalent.³ They consume a significant proportion of all Ontario inpatient resources, accounting for nearly 51% of all ALC/long-stay days in Ontario. To ensure the delivery of timely, seamless, and appropriate services for individuals with psychiatric disorders, therefore, ALC days and lengthy stays in hospital are important areas to address.

ALC days can extend a hospitalization for a few days or many months. We were particularly interested in patients with lengthy ALC terms (i.e., more than 90 days designated as ALC in a single hospitalization in acute care) or with extremely long stays in hospital (i.e., 6 months or longer in tertiary care) as they are using significant bed resources and may benefit from high support housing. These extremely long stays block beds in both acute and tertiary hospitals. In acute care hospitals, 60% of ALC stays in designated beds are lengthy according to the above definition. In tertiary care hospitals, 65% of long-stays exceed six months.

Our analyses indicate that these patients are impaired by multiple complex health and social issues that can be expected to contribute to difficulties in adapting to community living.

Compared to those without ALC days, they are more likely to have psychotic disorders, including schizophrenia, developmental disorders in addition to mental disorders (i.e., dual diagnosis), and co-occurring physical illnesses. Many also have co-occurring substance use disorders, although such diagnoses did not differentiate them from other patients without ALC days or with shorter stays.

Many of those with lengthy ALC terms or extremely long stays in hospital are involved with the legal system and the majority exhibit problematic, disturbing, or violent behaviours that are

³ As noted earlier, "long-stay" in the absence of ALC is defined here as hospital stays exceeding 90 days.

likely to interfere with healthy community living. To a greater extent than patients with shorter stays, they have significant issues with self-care and problems performing activities of daily living. They also have more problems related to cognition, communication, and decision-making. Further, they tend to exhibit lower insight into their symptoms and are at greater risk of being non-adherent with medications and other services. Their networks of social support in the community tend to be poor or exhausted, and they exhibit high rates of unemployment.

Finally, their pattern of health service use in the time leading up to and following the current hospitalization suggests a strong and persistent use of inpatient care for both physical and mental health reasons. Almost half of patients with lengthy ALC terms or extremely long stays in hospital had been hospitalized in the 30 days before their current admission. The data also suggest that few are connecting with primary care and other health services in the community following discharge. Notably, only half of these patients had a follow-up service billed to the Ontario Health Insurance Plan (OHIP, see Appendix D for further details) in the month after discharge, compared to over 90% of those discharged from shorter stays. Together, these factors combine to indicate a need for high levels of community support and flexibility in service delivery to successfully transition and maintain this sub-population of individuals with mental disorders in the community.

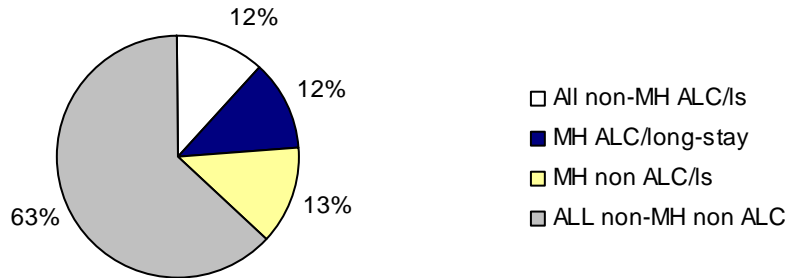
Findings for each of the above three objectives are summarized in more detail below.

A) How many Ontarians have mental health and addiction (MH/A) ALC or long-stay hospital days? ⁴

- Nearly 5,200 adults had a MH/A ALC or long-stay hospital day in fiscal 2007. They were roughly 12 percent of those who had a MH/A hospital stay during that year.
- These individuals accounted for nearly 1.06 million ALC/long-stay patient days, which equates to (Figure 1):
 - 12% of all Ontario patient days (i.e., hospital days for any mental or physical condition)
 - 51% of all Ontario ALC/long-stay days
 - 48% of Ontario MH/A patient days

⁴ These analyses exclude approximately 4,000 individuals with dementia. Included, they add an additional 209,000 ALC/long-stay days of which 69% are in a designated psychiatric bed.

Figure 1: Total inpatient days, FY2007 (n=8.7 million)



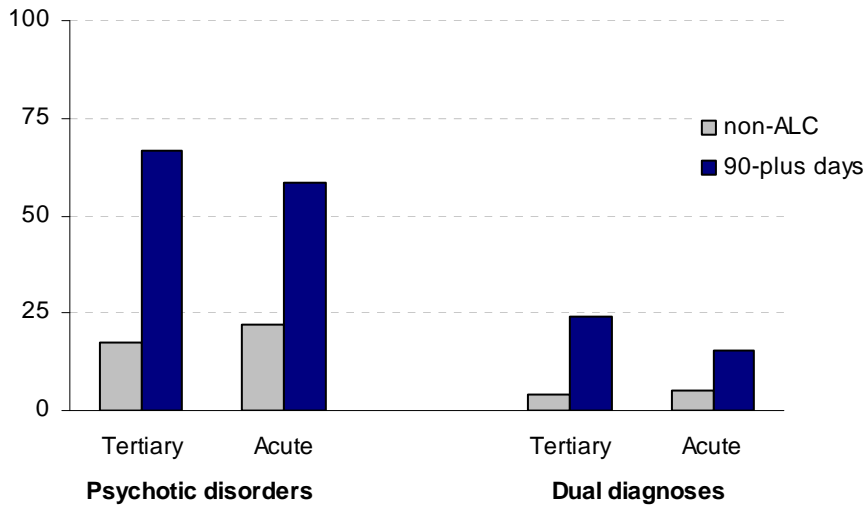
- Most (97%) of these 1.06 million ALC/long stay days occurred in designated mental health hospital beds, including:
 - 756,698 days occurred in acute care hospital designated beds.
 - 269,823 days occurred in tertiary care hospital designated beds.
- In acute care hospitals, 60% of the designated mental health bed stays with one or more ALC/long-stay days had more than 90 days that were ALC/long-stay. The figure rose to 65% in tertiary care hospitals (see Appendix C).

B) What are the main patient-level factors associated with having 90+ days of ALC/long-stay (relative to having no ALC/long-stay days)?⁵

- Being male (61% vs. 41% among those with no ALC/long-stay days)
- Being 65 years of age or older (12% vs. 5%)
- Living in an institutional, shelter, or assisted living setting just before being hospitalized (42% vs. 12%)
- Having a diagnosis of schizophrenia or other psychotic disorder (60% vs. 21%; Figure 2)
- Having a dual diagnosis (18% vs. 5%; Figure 2)

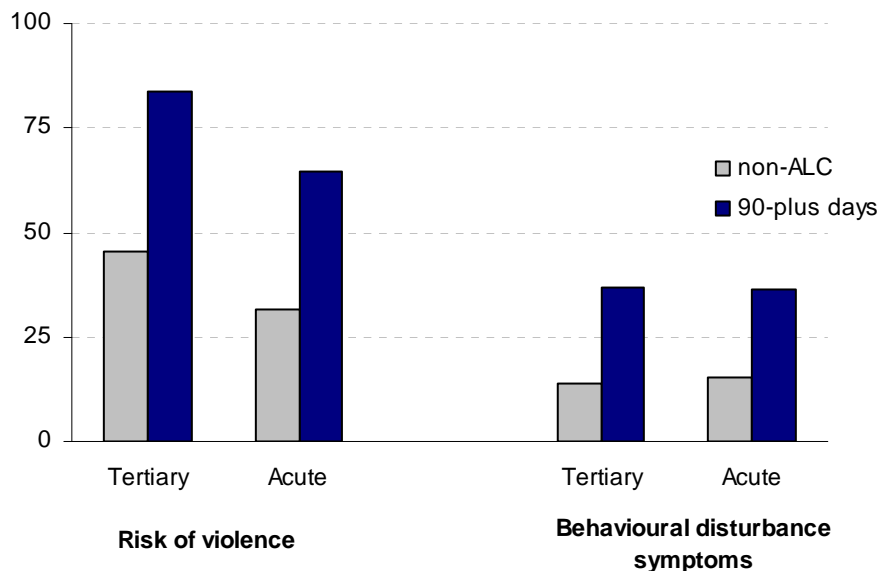
⁵ For a list of all the patient-level factors considered in this analysis, see Appendix C

Figure 2: Diagnoses associated with MH ALC/long-stay events by hospital type



- Having a physical illness (34% vs. 23%)
 - In acute care hospitals, the proportion of patients with a physical illness was 32% among those with 90+ ALC/long stay days versus 21% among those with no ALC/long-stay days.
 - In tertiary care hospitals, the proportion of patients with a physical illness was higher than in the acute care hospitals, but did not differ between those with 90+ versus no ALC/long-stay days (39% vs. 42%)
- Potentially benefiting from or needing a psychotropic drug review (99% vs. 65%)
- The difference according to ALC/long-stay days was greater in acute care hospitals (99% vs. 62%) than in tertiary care hospitals (99% vs. 87%)
- Having current involvement with the criminal justice system (34% vs. 6%)
- Currently, or having a history of, being a threat to others (Figure 3):
 - 70% of patients with 90+ days of ALC/long-stay were identified as at risk of being violent (vs. 33% of those with no ALC/long-stay days). This issue was particularly apparent in tertiary care hospitals, where the prevalence of risk of violence among those with 90+ days of ALC/long-stay was 84% (vs. 65% in acute care hospitals)
 - 36% had behavioural disturbance symptoms (vs. 15%)
 - 15% had a history of extreme behaviour disturbance (vs. 7%)

Figure 3: Problematic behaviour associated with MH ALC/long-stay events by hospital type



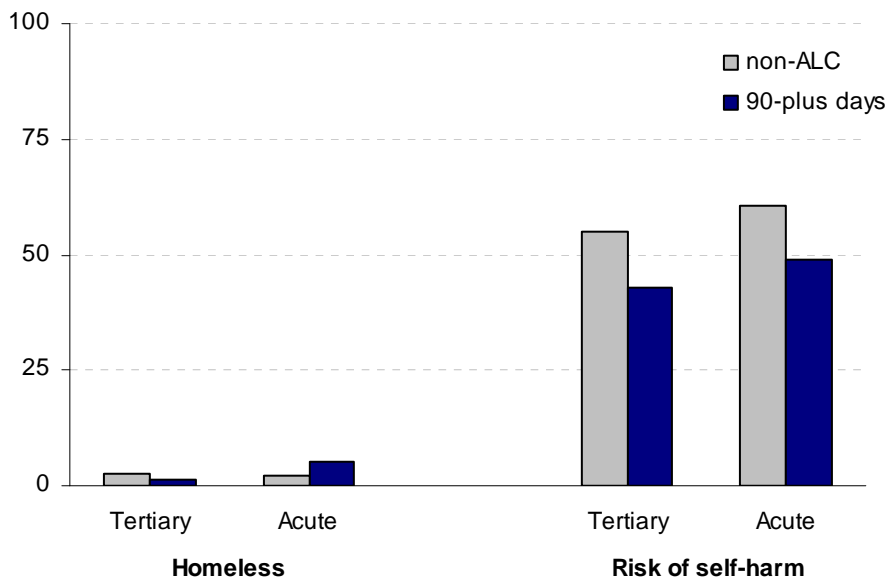
- Being engaged in addictive behaviours, including recent use of alcohol, illicit drugs, and/or daily use of tobacco (99% vs. 68%)
- This difference is most influenced by patients in acute care hospitals. In tertiary care hospitals, 99% of those with 90+ ALC/long-stay days were engaged in addictive behaviours, relative to 92% of patients with no ALC/long-stay days
- Addictive behaviours: tobacco smoking (43% vs. 33%)
 - The difference is again most influenced by patients in acute care hospitals. In tertiary care hospitals, the opposite pattern was observed: 33% of patients with 90+ ALC/long-stay days smoked tobacco, relative to 46% of those with no ALC/long-stay days.
- Addictive behaviours: alcohol and/or illicit drugs (56% vs. 34%)
- At risk of being non-adherent to treatment (88% vs. 50%)
- Showing poor insight into symptoms (84% vs. 43%)
- Having problems with cognition, communication, or decision-making (99% vs. 65-70%)
 - This difference is most influenced by patients in acute care hospitals. In tertiary care facilities, high proportions of patients (between 90-99%) exhibited these issues regardless of ALC/long-stay days.
- Experiencing difficulties in performing activities of daily living, including walking, wheeling and/or toilet use (33% vs. 7%), as well as instrumental activities of daily living, such as meal preparation and medication management (74% vs. 22%)

- Having problems with social functioning (99% vs. 67%)
 - This difference is again most influenced by patients in acute care hospitals. In tertiary care hospitals, 99% of patient with 90+ ALC/long-stay days experienced this issue, relative to 90% of those with no ALC/long-stay days.
- Having problems with bladder (12% vs. 2%) or bowel (10% vs. 4%) functioning

Selected Factors NOT associated with having 90+ ALC/long-stay days

- Being homeless (4% among those with 90+ ALC/long-stay days vs. 3% among those with no ALC/long-stay days; Figure 4)
- Having a mood disorder (20% vs. 33%)
- Having a concurrent disorder (18% vs. 40%)
- At risk of self-harm (47% vs. 60%; Figure 4)

Figure 4: Factors not associated with MH ALC/long-stay events by hospital type

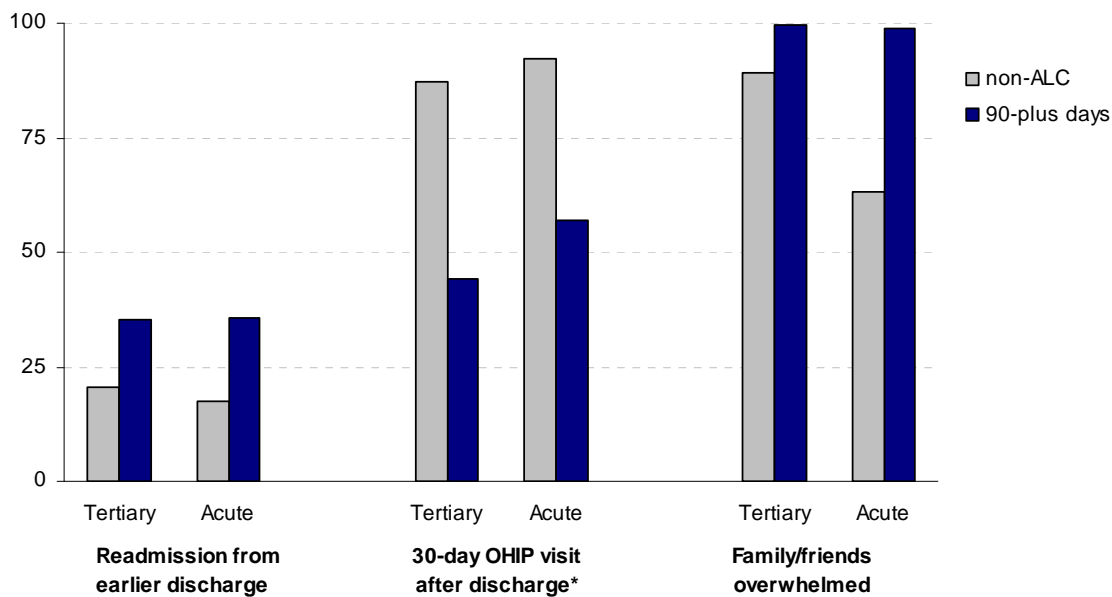


C) What happens to individuals with 90+ ALC/long-stay days after they are discharged?

In considering the outcomes of those with 90+ ALC/long-stay days, it is important to note that 42% were admitted to hospital from another institutional, shelter, or assisted living setting (compared to only 12% among those with no ALC/long-stay days).

- 18% were identified by hospital staff as not being ready for discharge by hospital staff (vs. 38% for no ALC/long-stay days)
- For 43% of those with 90+ ALC/long-stay days, the current hospital admission had occurred within 30 days of a previous hospitalization for either a physical or mental health problem (vs. 24% among those with no ALC/long-stay days). For 36% of those with 90+ ALC/long-stay days, this last hospitalization was also for a MH/A reason (vs. 18%; Figure 5).
- 78% were unemployed at the time of discharge (vs. 39%)
- 75% were identified as not having adequate social supports (from family or friends) to assist them with living in the community.
- In 99% of cases, family and close friends report feeling overwhelmed by the individual's illness (vs. 66%; Figure 5)
- Approximately three-quarters of those with 90+ ALC/long-stay days were not yet discharged at the time of analysis. Of the ones who had been discharged:
- 14% visited the emergency department for either a physical or mental health problem in the 30 days after their discharge (vs. 26% among those with no ALC/long-stay days)
- 52% visited an OHIP provider in the 30-days after discharge (vs. 92%; Figure 5)

Figure 5: Discharge factors related to MH ALC/long-stay events by hospital type



* excludes on-going stays

2. Focus Groups: Thematic Analysis

“We need to think differently to accommodate clients”⁶

The following summary reflects the key themes that emerged from the focus groups with care providers, policy-makers, and other stakeholders. Findings that are specific to certain sub-populations considered in this project (i.e., dual diagnosis, concurrent disorders, and geriatric mental health clients) are discussed in a later section (4. *Special Sub-populations*); however, many of these key themes were repeated for all ALC/long-stay clients.

A) Barriers to discharge

“Client rises and falls to our expectations, if expectations are set too low, don’t believe client can/deserves to leave, then (client) doesn’t believe they can either.”

Many barriers to discharge were found within the hospital setting, including staff attitudes and expectations of clients. Participants reported that hospital staff may judge clients by their past failures and set expectations too low, thus thwarting attempts to discharge. Community participants noted that hospital staff may fail to see that the client may not need to be 100% “recovered” to enter the community, while hospital staff noted that the community sector needs to appreciate that hospitals tend to be very conservative around risk issues (e.g., suicidal ideation and aggression). Discharge delays can result in beds lost in the community.

It was reported that clients are commonly excluded from the discharge process, which contributes to failures in transition. When left out of the discharge process, clients are less understanding of it and are less co-operative. The lack of dedicated hospital resources, such as transition teams, to work with clients, their families and the community around discharge exacerbates this problem.

Community participants frequently mentioned that hospital staff, particularly in Schedule 1 hospitals, did not seem to know what the community is capable of and what works in the community. They were equivocal over whether hospitals underestimated or overestimated their capabilities.

For various reasons, hospitals were commonly perceived as failing to involve the community adequately in the discharge planning process (e.g., sharing all relevant information with community providers). This is seen to reflect a lack of a

ALC/long-stay clients: A heterogeneous group

- Clients with histories of sexual offences, pedophilia, fire starting, aggression, previous failures in the community, chronic suicidality, polydipsia, and high needs for safety
- Geriatric, dual diagnosis clients
- Clients with intrusive behaviours, such as shouting, wandering, resistance to care, or poor hygiene
- Clients with co-occurring medical conditions, incontinence requiring nursing care, diabetes (increasing as the population ages), or obesity
- Isolated long-stay tertiary care clients
- Young clients with neurological disorders who need more nursing care
- Lower functioning individuals in their 40’s-60’s who require personal care and have little or no motivation to cook or clean for themselves

⁶ All quotations in this document come from focus group participants.

“bridge” between hospital and community. Community service providers frequently commented on the perceived attitude of hospital staff that, “this is now your problem.” This feeling is reinforced when hospitals do not provide receiving agencies with back-up. Both hospital and community staff thought more attention needed to be paid to understanding that “discharge does not happen in a day.” When discharge occurs too quickly, the community sector is not ready to receive the client. It was agreed that these issues contribute to a lack of trust by community providers resulting in their unwillingness to accept more challenging clients.

At the client-level, barriers to discharge are associated with behaviours and conditions that are challenging for many community programs to handle (see Text Box inset), difficulties that can result from the experience of long-term hospitalization, and the transition process itself. Long-stay clients can be overwhelmed by change and the threat of loss of the comfort of the hospital. This is frequently coupled with a feeling that they are unprepared for the community and the reality that they have no informal supports. Their tenure in hospital may have resulted in not feeling responsible and/or motivated to care for themselves, sometimes referred to as *learned helplessness*.

Clients are likely to face many obstacles once in the community that can be frightening to them, especially when they lack adequate social and informal supports. They may have concerns about where they will fit in once they go back; for example, those returning to small towns frequently experience stigma, while those returning to live in big cities can feel lost. Participants warned against underestimating the magnitude of the change for the client which can result in refusal of placement.

Families too frequently believe their loved ones would be safer and better taken care of in the institution. They commonly have misconceptions about the capability of community care resulting in family refusal of placement options.

Regarding the community setting, there was a general agreement that the lack of high support housing with 24-hour staffing and the capacity to accommodate clients with complex mental health and co-occurring illnesses represents a significant barrier to discharge. Where such housing does exist wait-lists are long. This leads to both high levels of ALC/long-stay clients who are under pressure for discharge and clients with complex needs being discharged to housing that under-serves them (e.g., homes for special care or boarding homes).

It was noted that the majority of housing staff lack adequate training to deal with people with complex mental health problems. The shortage of personal care workers in housing is also problematic for the low functioning and aging clientele. Frequently mentioned was the difficulty that clients with mobility problems experience when living in older housing stock with poor accessibility.

In addition, participants in all focus groups commented on the lack of a full continuum of housing alternatives in most communities. This was viewed as restricting the flow and movement of clients into housing that is most appropriate to the level of need.⁷

⁷ Participants noted that many general hospital clients need more care but are not high acuity. They become ALC in hospital although they would do well in an intermediate community residence if such were available.

The range of community support services needed for complex mental health clients is typically unavailable due to resource shortages and long wait-lists. The most frequently identified services were ACT, case management, and community-based medical and psychiatric care: “it can’t be stressed enough how very difficult it is to find doctors who will serve this clientele in the community.” It was also noted by one participant that generic services need to be adapted to the high support needs of this clientele. In one participant’s words, “the approach has to be different (with this clientele) and this involves a shift in thinking.”

The fact that CCAC’s do not have a mental health mandate across the lifespan was viewed by many as a serious shortcoming in the present system. As a result, CCAC’s have interpreted their roles *vis-à-vis* mental health differently (i.e., some will provide supports in mental health supported housing units and some will not).

B) Engaging the client and family in the transitioning process

“We have to figure out how to engage people. We miss opportunities when we decide what people need”

Both hospital and community mental health participants stressed the importance of client engagement throughout the transitioning process, advocating that clients be viewed explicitly as active participants. The allowance of sufficient time is a particularly important element in the process of preparing the client for discharge. Participants felt that priority should be given to client preferences, and that they be incorporated into the discharge plan. In all focus groups, the need for individualized discharge plans was stressed, along with a requirement that service providers be flexible and adaptable in meeting client needs. Going forward, several participants stated that discharge planning should begin at admission, that clients should know hospitals are “not for life”, and that they should be engaged in thinking about suitable discharge from the start.⁸

“The client gets value when you take the time to transition”

Tailored placements that reflect a good client fit with the environment are a feature of successful transitions. For very long-stay clients, discharge may need to be repackaged to help them see that they can live in the community. Focus group participants underlined the value of taking time to go through the important steps of client assessment, as well as meetings between the client, receiving community services, and hospital staff, to help “pave the way” for the client. While taking these steps is more time intensive, it is viewed as more effective in the long-run. Trial placements are recommended to assess community readiness and fit with the service.

The use of peer support was stressed in the majority of focus groups. Peer support programs are seen to help ameliorate client fears and concerns around discharge. Peers act as “bridges” between hospital and community and help clients to adapt to community life and to develop

⁸ This does not apply to current ALC/long-stay clients

support networks outside of the hospital (Forchuk et al, 1998).⁹ For example, Providence Care Mental Health Services incorporated peer support into a large transition project for 18 long-stay patients. They started with peer support for inpatients to instil in them an “esprit de corps” around leaving hospital that was carried into the community residential placement.

Recognition of the important role played by families in the discharge process, and the need to engage them as allies were viewed as critical. Participants felt that it was important to offer families all the information they need about community services so they can be assured their family member will be safe and will receive appropriate care. Otherwise family members experience difficulty in agreeing to a placement. This was particularly noted for dual diagnosis clients.

Most focus groups endorsed a client-centred approach based on recovery principles and rehabilitation, both in hospital while preparing the client for discharge and in the community. In the case where one hospital explicitly adopted a recovery approach, staff perceptions of long-stay clients shifted dramatically and they were able to see fresh potential for change. These workers felt that shifting to the recovery approach made them more effective in engaging with community agencies and in moving clients through the transitioning process.

C) System-level transitioning strategies and processes

“Hard to operate as a system when treated as a silo.”

System-level approaches to dealing with ALC/long-stay clients were widely discussed in the focus groups. When large scale efforts are made at the system-level, transitioning becomes more streamlined and uniform in approach. For example, partnerships can be fostered and developed through convening the LHIN mental health and addictions planning table for the purposes of sharing information, problem-solving, and dealing with pressing issues. Within the NE LHIN, the mental health and addictions planning table has expanded to include other relevant sectors, allowing the district to identify gaps in service and to fashion care plans tailored to the individual. This was based on the observation that clients use programs and services that are outside the conventional range of mental health and addictions services, such as faith-based services.

Additionally, the NE LHIN will be adopting a shared accountability model for hospital admission and discharge. This will involve all service providers within the LHIN and will focus on the impact of ALC/long-stay mental health clients on bed use and resources. It is expected to lead to the more efficient use of resources and to the identification of positive collaborations and other ways to address the problem. In the HNHB LHIN, the formation of an ALC steering committee to look into ‘hard to serve’ populations helped to identify characteristics of mental health clients and develop strategies for discharge.

⁹ In Ontario, CMHA Brantford peer support workers meet with clients to help them be less fearful; Niagara is getting funding for peer specialists; and both PCMHS and Sudbury regional district also make use of peer support workers.

At a district or more local level, three examples of systems planning illustrate the benefits of taking a systems approach. In the Sudbury District, a “systems of care” committee targets those who are most difficult to discharge and brings all relevant players together to assist in discharge planning and creative problem solving. The committee develops services around the individual, assesses who has funds and identifies who can provide services. In Sault Ste. Marie, service providers have formed a “difficult to serve” committee for individual case conferences and to identify staff needs and provide training. The hospital is set up to respond to community calls (24/7) for assistance with issues associated with placement and will readmit individuals when the need arises. There is a two-year follow-up during which the committee provides support to the individual and the receiving agencies. Thirdly, London has created a community-based problem-solving committee for dealing with complex clients who are difficult to manage in the community. Service providers were very positive about this group, finding it offers them necessary assistance and support that aid in better management.

Hospitals, using a systems approach found that they were more effective in transitioning complex clients. Participants suggested that when hospitals recognize that there is a large system component both within the hospital and in the community that needs to be dealt with, transitioning is made easier. This involves changing hospital behaviour and attitudes and becoming more flexible. In another example, a tertiary care facility responsible for a large geographic area reported success in enhancing continuity of care through video-conferencing by connecting care providers with each other and by connecting clients with providers in the communities to which they return.

Participants felt that the potential role of the CCAC’s with mental health clients needs to be explored. We are aware of two CCAC’s (i.e., Central and Toronto Central) that currently offer mental health “system navigation”, linking people to needed services.

A pervasive problem noted by participants concerns existing constraints around use of funds. These constraints prevent agencies and hospitals from moving funds to where they will be of most potential value. A recent experience in the North with a flexible funding pilot project was successful in lowering the extent of ALC because funds could be deployed to support clients in non-traditional ways that were particularly beneficial to the individual (e.g., creation of wraparound services). Participants argued strongly that greater flexibility in funding could produce an overall positive effect on ALC/long-stay days.¹⁰

Flexible Funding

A recent example of flexible funding took place in the North and involved the successful relocation of a client to her home community. With cooperation from multiple funding sources (Association for Community Living, HSC, and the hospital), money was “moved around the system” to build the services needed to support the client.

¹⁰ In this context there was considerable discussion around the deployment of money for Homes for Special Care (HSC) to provide needed services. The HSC program is not viewed overall as particularly viable for complex clients with high needs, with some exceptions noted (e.g., PCMHS). One area in the North cited significant vacancies in their HSC program due to problems in finding suitable landlords. They advocated for being able to use the funds differently (e.g., in the provision of wraparound services).

Another system-level problem that was frequently mentioned, and for which there is no simple solution, was that of funding for transportation costs. ODSP does not include funding for transportation to non-medical appointments due to lack of funds for transportation, imposing a significant service barrier for clients in rural and/or remote areas. This speaks to the need for greater co-ordination between MCSS and MOHLTC in recognition of the multiple ways in which clients cross ministerial boundaries.

D) Service-level transitioning strategies and processes

“A shared discharge planning process is needed, the hospital and community need to work together.”

Participants placed strong emphasis on collaborative discharge planning processes that involve hospital and community providers.¹¹ The transitional discharge model is a collaborative model that uses a carefully planned client-centred discharge process with both “in-reach” and “out-reach” components (Forchuk et al, 1998). Overlap between hospital and community providers helps to build new therapeutic relationships while maintaining old ones. The community service gets to know the client before discharge. Hospital staff take the client to meet other residents so that he/she can begin to feel comfortable and secure before discharge. This approach ensures that adequate and appropriate supports are in place for the client in the community and begins to prepare them to live in the community. The sharing of information and perspectives helps to situate the client in the most appropriate setting. A further advantage of transitional discharge is that it builds capacity within the community to work with more complex clients through the active collaboration with and ongoing involvement of the tertiary hospital. There was uniform agreement that high-level community engagement is essential to a successful transitioning process.

Hospitals build collaboration through other important means, such as by providing:

- Post-discharge follow-up and monitoring
- Access to tertiary care expertise after discharge
- Psychiatric back-up¹²
- Quick readmission policies, such as “take-back” agreements or by-pass arrangements
- Community rounds in hospital

These actions are viewed by the community sector as being essential elements of a successful hospital-community collaborative relationship. Their presence contributes enormously to trust in the relationship and security for the receiving community housing agency.

“We’ll do whatever is necessary and take however long it takes (to transition), one client at a time. It’s a concerted approach.”

The adoption of a creative, flexible, committed approach to discharge enables transition. In the words of one participant, attitude is an important component of a successful discharge strategy.

¹¹ While the role of social work in the discharge planning process was not articulated by focus group participants, it should be noted that in most hospitals social work take a lead role.

¹² This was seen as particularly more problematic with Schedule 1 hospitals

Flexibility enables hospital staff to respond to the needs of the client and community. For example, using trial placement periods, or “guest agreements”, one to two months before permanent residency allows the client to demonstrate community readiness and allows for further needs assessment and fine tuning of the environment.

Hospitals reported success when they made a commitment to focus on discharging their ALC/long-stay patients. This focused commitment translated into a range of activities such as:

- Active review and monitoring of ALC/long-stay inpatients (e.g., “ALC Surveillance”), combined with ongoing efforts to discharge long-stay clients
- Case conferencing with refusing agencies to find out what must happen for them to accept the client
- Putting needed services in place through the active pursuit of hospital-community partnerships
- Using discharge checklists to help hospital and community work together and ensure that everything is covered off in the discharge process

On the community side, it was mentioned that placing a staff member inside the tertiary care facility helps to facilitate the referral and discharge process. One participant noted that “good service co-ordination”, involving hospital and community services working together, is the critical piece in this regard.

“Overall, individuals need to feel that there is support for them, even if they ‘fail’ in the community – need to have a team of individuals to support client.”

Specialized teams in the hospital and community were noted as being effective transitioning components. Two examples were provided: the Community High Intensity Team (CHIT) at Providence Care Mental Health (PCMH) and the Transition Team in Waterloo. CHIT is a multi-disciplinary team, including nurses, occupational therapy, and social workers, that accepts referrals from within the hospital for patients about to be discharged. The team follows clients post-discharge in the community, working closely with housing staff and offering training where needed (e.g., diabetes management). It takes a holistic wellness perspective towards the health of the client including the need for clients to develop their own social networks in the community to replace the more familiar hospital networks. CHIT enables the transitioning of very complex, long-stay clients. The Transition Team in Waterloo consists of a similar staffing compliment. It receives clients when they are ready for discharge from London and supports them until they can be picked up by case management or an ACT team. The team connects them with other services as needed and depending upon availability (e.g., housing, psychiatry, and ICM).

The service resolution support offered by Trellis in Kitchener-Waterloo also helps to resolve service-related barriers that inhibit transitioning of complex mental health clients. It works to promote service co-ordination and engage providers in meeting clients’ short and long-term needs. Service resolution targets adults who are experiencing increased difficulty accessing services and have urgent needs.

“Success depends on (the) individual’s consent to the plan, the availability of both housing and clinical services, access to income support as well as access to any other unique services

required by the individual. All these factors must align with the individual’s readiness for discharge.” (PCMHS, Community Resources Plan, 2008) (see Appendix E)

E) Staff education and training

Participants agreed that to expect community mental health service providers to accept increasingly complex clients requires that community staff be equipped with the requisite expertise, knowledge, skills and attitudes (i.e., do they know who can leave, do they believe people can succeed, are they informed about resources). Without exception, education and training for community mental health staff is seen as integral to effective transitioning. In practice, there is a considerable amount of training being offered by tertiary and some acute care providers on the competencies of caring for complex needs clients. For instance, one tertiary care facility has successfully trained residential staff around diabetes care.

Requisite skill requirements for community mental health staff include specialized training in co-occurring illnesses such as dual diagnosis and concurrent disorders. Specialized skills and knowledge related to the management of aggression, verbal de-escalation techniques, cognitive-behavioural interventions, crisis intervention, and risk assessment were commonly mentioned. Basic professional mental health training, recovery-based training, collaborative relationship development and both system and community-based knowledge are considered foundational.

“People need a passion to serve the ‘hard to serve’ individuals.”

Positive attitudes towards working people with complex mental health problems in the community were deemed very important. In particular, participants cited tolerance, hopefulness and flexibility, and seeing the potential of clients as most important.

Participants felt that more education is needed to raise the skill levels of hospital staff around assisting clients in transitioning to more independent living. As previously mentioned, the adoption of a recovery approach can be enormously helpful.

F) High support housing

In London, **WOTCH** runs a transitional residence (3-6 months) that is client-focused and recovery-oriented, and serves as a step-down unit for people leaving hospital to other housing.

In other cases, a **transitional residence** can be a step-down between high support housing and independent living. Generally, participants endorsed the idea of transitional housing for individuals who can move on to more independent housing. “*Transitional living for some after a long time hospitalization is central to successful reintegration into the community.*” (Specialized Residential Rehabilitation)

“Clients need ongoing support but don’t want an institution in the community”

As previously noted, the term *residential treatment facility* is considered outdated and the preferred term is now *high support housing*. Regardless of terminology, this type of housing is conceptualized as having both housing and treatment components and as being provided in either secure settings or home-like, non-secure settings with 24/7 supervision and monitoring.

Participants strongly endorsed the need for more high support housing and stressed that there is a need for both long-term (in some cases permanent), and transitional housing. As long as there is a shortage of housing, ALC/long-stay clients in hospital will remain an issue. It was noted that the vast majority of these clients require 24/7 supervision and monitoring upon leaving hospital for varied periods of time. One acute care hospital provider stated that at any given time their inpatient unit had from two to seven ALC patients who could be discharged to high support housing if it was available. Similarly, a tertiary care provider suggested that they would be able to immediately discharge 20 long-stay patients if 24/7 high support housing was available. Similar observations were made throughout the focus groups. In addition, availability of ACT and case management services were considered important elements in short supply.

“The challenge is to be more than purely custodial and to provide treatment, rehab, and safety for the client, the staff and the public.”

Based on participant feedback, model high support housing would include the following:¹³

- 24/7 supervision and monitoring with a minimum of two staff on at all times
- Multidisciplinary, highly-trained staff, including recreation specialists, nursing, occupational therapy, social work, personal support workers, and residential or community-based case managers
- Home-like environment
- An environment that offers safety and security for staff, residents and the community (e.g., a securable setting)
- Resident privacy (i.e., own bedroom and bathroom) as well as congregate living areas
- Good location with access to public transportation and services

Participants further noted that model high support housing *programming* should include the following features:

- Holistic, biopsychosocial approach to wellness
- Promotion of integration and community contribution
- Client-centered, individualized plans that include functional and physical assessments, and risk assessment management plans
- Recovery oriented services, including peer support, supportive counselling, and life skills, social skills, and vocational training
- Linkages with primary care-family physicians and nurse practitioners
- Tertiary or acute care psychiatric back-up
- Flexible guidelines
- Defined emergency/crisis protocols, including clearly outlined roles for staff, police, mental health workers, and hospital

“The art of the possible”

PCMHS and Frontenac Community Mental Health Services entered into a collaborative relationship to provide housing and support for 18 long-stay inpatients through the Lower Union Transition Project. Shared service plans were developed for each person. Lower Union offers 24/7 staff and programming for interpersonal relationships, medication, education, nutrition, ADL, spirituality, and finances. Peer support was incorporated throughout the process. Facilitating the process was a protocol developed by the partnership that outlined the specific roles and responsibilities of each partner.

¹³ Some areas of the province are discharging to HSC and adding case management for support. These homes are not viewed as adequate, but are used because they accept long-term patients and are available.

- Public health teaching around safe sex and STD's

The high support housing characteristics identified by participants do not necessarily reflect what is available. Regarding the requirement for 24/7 supervision, participants noted that they encounter difficulties when monitoring is required due to insufficient funding for requisite staffing. Different ideas were offered about how to provide some of these features. One informant recommended that essential services and supports be tied into the housing. Currently they are funded separately, which can lead to people in housing without adequate clinical services (see Appendix F).

Resident access to clinical and medical care can be especially challenging. It was suggested that high support housing services should form ongoing linkages to primary care and other clinical staff who are expert in chronic disease management. However, these linkages can be difficult to make. Another approach would be to create mobile high support multidisciplinary teams that are attached to high support housing and provide specialized expertise and support to residential staff and complex ALC/long-stay clients.¹⁴ Residents could be linked to ACT teams; although these would need to be available and willing to accept them.

Given the high prevalence of people with concurrent disorders in need of high support housing, one informant recommended that flexible funding be used to provide addiction treatment services for individuals in high support housing and spoke to the need to develop appropriate harm reduction programming in residential programs.

“We simply cannot have too many options (housing).”

The second most frequently mentioned issue was the need for a continuum of housing alternatives¹⁵ of which high support housing is one component.¹⁶ Such a continuum would include both long-stay and transitional high support housing, housing with less intensive supervision and monitoring, group homes, individual apartments, emergency or crisis housing, and specialized housing for people with concurrent disorders, dual diagnosis, or geriatric mental health issues. A housing continuum that allows for client movement and choice is best able to respond to changing needs over time. For example, many clients will only require high support housing for a time-limited period after which they will be ready to move onto more independent living. Others may require it for life. Many housing providers reported success in moving clients from high support to more independent living. In the words of one worker, “people rise to the occasion.” Yet, due to shortages of housing and gaps in the continuum, those providing high support housing are typically operating at capacity and finding it difficult to move residents on to more independent living once they are ready.

¹⁴ A similar model was described in the proposal for *Specialized Residential Rehabilitation Treatment, Champlain District 2001*.

¹⁵ We recognize that the term *continuum of housing* has come to denote a housing model that requires people to move as they improve. As it is used here, it refers to a having a range of housing alternatives available where mandatory movement is not required, including transitional housing that is designed to be a stepping stone between hospital and more independent housing.

¹⁶ In a proposal for specialized residential rehabilitation treatment (*A Model for Champlain*), the primary objective was to have the individuals move on to more independent living when they were ready. For this to occur, a housing continuum with appropriate treatment and supports is essential.

Similar problems exist in accessing specialized ACT teams, case management services, and 24-hour mobile crisis services. To this end, focus group participants recommended building a system of care that is inclusive of the span of residential alternatives and community mental health services and supports needed for people with complex mental health problems.

To conclude, focus group participants agreed there is an overall shortage of adequately funded, available high support housing, and that most communities do not have a robust continuum of available housing. With the MOHLTC funding infrastructure, the lack of funding for residential support staff translates into high support housing that is under-resourced and falls short of model housing.

3. High Support Housing Surveys

A recent CSRU-led survey of high support housing, conducted in conjunction with the *High Support Housing Consortium, Toronto*, yielded important information for this report. The survey's objectives were to gain an overview of the population being served and an understanding of the challenges facing housing providers. The following summary of their findings is coupled with the results of a similar survey conducted as part of the present project and sent to focus group participants in other areas of the province.

The CSRU concluded that there is an inadequate supply of high support housing and insufficient supports for clients with high mental health needs. The consequences of this "system imbalance" are serious, resulting in clients' inability to access appropriate housing, the blocking of inpatient beds, premature admission to long-term care, and discharge to inappropriate housing with inadequate supports leading to relapse and hospitalization.

The existing clientele being served by high support housing was complex, with variable rates of concurrent disorders (20-90%), dual diagnosis (2-20%), criminal justice involvement (15-100%), and disability and other health issues (30-75%). Two-thirds (67%) of clients were receiving case management, while 13% were receiving ACT. Our companion survey revealed considerable variance across programs, with 6-100% of clients receiving case management and 0-60% receiving ACT.

Provided services were described as recovery-focused, client-centred, flexible, individualized and tailored to the needs of people with severe and complex issues. In-house programming and on-site staff services were being provided by professionally trained and educated staff. Specific in-house services included metabolic monitoring, medication management, psychosocial programming, laundry, meals, recreation, transportation, hygiene and housekeeping. Generally, there was an emphasis on life skills and social recreational programming with each setting having its own particular basket of in-house programs.

High support housing providers stated that they needed more in-house staffing for 24/7 coverage and for case management and personal support workers. The latter were mentioned frequently for the aging population. Staffing ratios varied considerably, as did the particular mix of disciplines. In our companion survey, without exception, respondents spoke to the need for

nursing services either on site or with linkages to in the community. External support needs encompassed greater access to medical and psychiatric consultations, clinical linkages, recreation therapy, dietician support, occupational therapy, employment counselling, and staff training. The extent of current linkages varied considerably from program to program.

The average cost per diem of high support housing was \$102.70, compared to \$1048 for an inpatient bed in an acute care hospital and \$665 for a bed in a tertiary hospital. In our survey, one response from a high support housing provider indicated a cost of \$229/day. Apart from housing costs, however, there are external agency costs for case management, ACT, and other services, which add to the overall cost of care in the community.¹⁷

The CRSU report concluded that the needs of high support clients could be met in high support housing but there was an inadequate supply of housing stock. Availability of additional services, such as specialized medical services and hygiene support, would augment current service provision in high support housing. In addition, access for some populations (e.g., those with poor hygiene, high medical needs, poor compliance, substance use, behavioural disturbance, lack of involvement in a program, and/or mobility problems) continues to be restricted.

4. Special Sub-populations

The project gathered additional in-depth information on three sub-populations: dual diagnosis, geriatric mental health, and concurrent disorders. The following sections include relevant findings from the literature scan, focus groups, and key informant interviews. For dual diagnosis, a special focus group (n=17) and survey on the treatment beds specialized accommodation program (n=7) were conducted. Herein, we present information that adds to our understanding of the particular challenges facing these groups.

A) Dual diagnosis

i. Findings from the literature

In 2001, the UK government highlighted the role of specialized mental health services for dual diagnosis clients. In their report, the need for special training of health professionals and service providers was acknowledged, as many support workers do not understand the unique needs of these clients and, as a result, do not seek out appropriate services in the community. Xeniditis et al. (2004) assessed the impact of specialized services in-hospital which provide comprehensive assessment, recommendations and therapeutic interventions, and help ensure appropriate care plans are transferred to community settings on discharge. In this study, multidisciplinary teams, including input from health and social care providers and family members, along with a “person-centered” approach, were emphasized for discharge planning. Additionally, it was recommended that patients voice their preferences and needs with regard to residential options. A recent

¹⁷ While high support housing costs less than hospital beds, it is more expensive than traditional custodial models of housing. Other cost estimates include \$150-250 for non-secure settings and \$300 for secure settings (Seven Oaks, Victoria, BC; Trainor & Ilves, 1999).

Toronto-based study on a specialized program took a similar approach and reported similar findings (Lunsky & Palucka, 2009).

While inpatient stays may be generally longer in specialty wards that offer a range of services, positive outcomes are found for improvement in psychiatric symptoms, overall level of functioning, and reduced mental health problems and behavioural disturbance. Increased time taken for discharge planning tends to result in more appropriate discharges and greater success rates than when placements are under-supported or “out of region” (Lunsky et al., 2008; Watts et al., 2000). Specifically, Xenitidis et al. (2004) noted a reduction in aggressive and challenging behaviours among 80% of residents who were discharged from a long-stay hospital (described above) at six-month and one-year follow-ups. Further improvements with respect to QOL and satisfaction have been shown when dual diagnosis clients can access this type specialized of care (Van Bourgondien et al., 2003).

The need for hospitals and community agencies to function as a continuum through collaborative relationships and partnerships is emphasized in the research literature. Namely, a balanced delivery of health care is important where specialist services work collaboratively with other agencies and hospital supports. Specialized services have recently been created internationally (i.e., in Canada, the US, Turkey, and Finland; Xenitidis et al., 2004); however such support systems are still lacking in many areas and there is widespread diversity in service provision across regions (Lunsky et al., 2007).

Finally, a recent study of ACT teams and dual diagnosis showed that dual diagnosis clients account for a variable proportion of those served, ranging from 19% to 5.2% (Burge, 2009). Scientists were unable to account for the wide variation. The majority of respondents, when asked about training needs, indicated medium to high level of need (80%). To address this, “comprehensive specialized joint-sectoral” training programs were recommended with standardized training competencies outlined and a training format that addresses contextual differences (i.e., mental health, developmental services), as well as differences in terminology and planning processes.

ii. Findings from the focus groups

Barriers to discharge

“The lack of relationship between the two systems is common to all but it might be greater for dual diagnosis because the community system is funded by a different ministry with a different philosophy and different skills set (not a community mental health skills set).”

Clients with dual diagnosis require services from two sectors, MOHLTC-mental health and MCSS-developmental services. These two ministries need to improve coordination/communication. While the developmental services sector can provide 24 hour care for high need clients, it relies on the mental health sector to provide essential mental health supports. Developmental services provide some mental health supports, but the feeling is that

more should come from the MOHLTC. Strong partnerships with mental health teams would bridge this gap. Good examples of robust partnerships with mental health teams were noted.¹⁸

The *Dual Diagnosis Inter-Ministerial Joint Policy Guidelines* provides guidance for community mental health services regarding, how the two sectors can effectively work together to support complex dual diagnosis clients. Given the large role played by hospitals, their inclusion in the Guidelines was seen as an important next step. Participants recognized that to effect desired change, both additional resources and greater synergy between the two systems were needed. As one person stated, “they need to be re-jigged.”

Additional Discharge Barriers

- Generic ACT teams are not appropriately well equipped or trained to serve dual diagnosis clients. Currently there is only one dual diagnosis ACT team in the province (located in Brockville). In addition, ACT teams are most often at capacity.
- Individuals with dual diagnosis require more staff and more highly trained clinicians than are currently available. New models apart from ACT need to be explored and developed.
- Developmental services can be difficult to access for individuals who have no history of receiving them, and/or who have a history of forensic involvement.
- Recruitment and retention of well-trained staff is an issue for community agencies.

Participants noted that specific guidelines for hospitals that outline how to work collaboratively with developmental services and community mental health agencies to plan discharges would be helpful. Dual diagnosis patients typically present with complex needs requiring longer hospital stays. Complications arise because a major challenge for hospitals concerns the need to discharge dual diagnosis patients to “free up beds” and these individuals may be “off the radar” of developmental services, meaning that no bed has been set aside for them. In addition, when a dual diagnosis patient occupies a hospital bed, he/she is not classified as being “homeless” by the developmental services sector and is not given high priority for planning purposes. Participants suggested that hospital staff work with community dual diagnosis teams to prioritize these ALC clients so that they can be placed. This practice has been quite successful in some dual diagnosis programs in tertiary hospitals. Partnerships involving acute care hospitals and dual diagnosis programs are less common.

Other challenges concern the pace and manner in which the two sectors work. Hospital transitioning is focused on getting patients “in and out” of hospital. Alternatively, community resources are “more considerate of life-long planning.” The availability of specialized funds can facilitate the transitioning of clients and provide support to them in the community. These funds may be required for a long-term or even permanent basis.

“The dual diagnosis population is difficult to serve well”

There was a strong perception that clients with dual diagnosis suffer even greater stigmatisation than other clients from tertiary hospitals. It was noted that in some regions of the province, the tertiary care hospital long-stay dual diagnosis patients are considered the “worst of the worst.” It appears that the community has decided beforehand that such clients are too complex to consider

¹⁸ Concerns were expressed around new legislation possibly opening the door to higher functioning individuals and making it even more challenging to provide necessary services for clients with dual diagnosis.

Case Resolution

Case resolution facilitators coordinate a process for service providers around the provision of services for particularly complex dual diagnosis cases. A client is referred to case resolution once all community resources have been exhausted. The whole community, both the mental health and developmental sectors, is brought together to case conference and formulate appropriate plans. Following this, flexible funding is attached to the client. This process frequently results in the creation of partnerships. Four such facilitators are funded by MCSS.

for community care. Medically fragile dual diagnosis clients and/or technologically dependent clients are especially stigmatised, presenting an even greater transition challenge.

Additionally, long-stay patients may lack appropriate documentation, social supports, and advocacy which further weakens their position in the system and hinders treatment planning. For many individuals, long-term institutionalisation has left them with minimal community

skills and a behavioural repertoire that has been adapted to a hospital environment. Additional time and support is required to help them adjust to living in the community. Finally, regional MCSS decisions around funding for homes/beds could be made with more consideration of the types of beds/homes that would be most appropriate for this client group. (see below section on *Lessons learned from the treatment beds specialized accommodation program*).

Engaging the client and family in the transitioning process

Participants noted that it is very challenging for these clients to articulate their preferences and provide input into decisions concerning community placement. For those lacking family involvement and/or advocates, hospitals must make placement decisions in isolation. Where families are engaged in their child's life, their involvement in discharge planning is essential for successful transitioning. Skill and sensitivity among hospital and community providers is required to work effectively with families. Otherwise family resistance to discharge planning is commonly expressed out of fear of losing the security of the hospital placement and a lack of knowledge of what the community has to offer. Developmental service workers place a high value on involving families in the transitioning process.

Model Transitioning Steps

Respondents strongly endorsed the following key transitioning and discharge ingredients:

- Continuity of care from hospital to community
- Availability of staff who can cross boundaries (boundary-spanners) between hospital, community, developmental services, and mental health
- Start discharge planning early, in some cases at the time of admission
- Include community providers, the client, family and friends, advocates, as well as key hospital staff on the planning
- Community staff should attend meetings in hospital, spend time with the client in hospital, and take the client out of hospital gradually until ready for discharge
- Outings should include involvement in community activities, establishment of community routines and preferences, and short visits followed by overnight and longer visits to the home
- Provide community staff with bed availability and back-up from the hospital with specific agreed-upon readmission plans or contracts
- Provide psychiatric follow-up after discharge from the hospital
- Use a slow and flexible process
- Develop crisis support plans for clients and engage community-based crisis services

Transitioning processes and strategies

Transitioning processes and strategies for the dual diagnosis population were very similar to the general population. There was however a much stronger emphasis on the use of wraparound services, including a flex bed system. The importance for all relevant agencies and organizations involved in the process to understand each other's mandates was stressed. Because two different sectors are involved, participants spoke to the need to delegate responsibilities within the system, identify accountabilities, and create a fixed point of responsibility to drive the process and build trust. Finally, given the nature of the problems associated with dual diagnosis clients, a very slow transitioning process for moving clients into the community, coupled with an intensive level of support and safety net, were seen as essential ingredients of a successful plan.¹⁹

Participants observed that successful placement is enabled by access to multidisciplinary clinical teams, who can assist with prevention and management of crises and ongoing clinical issues. This type of support should include the option of re-hospitalization when treatment or stabilization is needed without threat of losing housing.

iii. Lessons learned from the treatment beds specialized accommodation program

Many of the themes reviewed above were reinforced by the information gathered from our survey of the *lessons learned from the treatment beds specialized accommodation program*. This program was designed to effect successful transitions of patients with dual diagnosis from hospital to community. We reviewed survey feedback from seven providers from across the province who work in tertiary settings or who have placed individuals from these settings into the community. We report here only supplementary information to that reviewed above.

Key discharge planning and transitioning ingredients

Several respondents highlighted the importance of having an appropriate bed available in the community as key to the discharge process, recognizing that teams need to be able to create environments "designed to address individual issues". *Kerry's Place*, an agency that specializes in providing high support to individuals with autism spectrum disorder (including Asperger's) and complex behavioural needs, has a range of housing resources including rural settings with ample outdoor space, communal living, and individual apartments. The latter are seen as necessary for some individuals with autism who have a difficult time negotiating the unpredictable behaviour of others.

Another key ingredient mentioned frequently is the relationship between members of the two teams (i.e., mental health and developmental services). Respect, honesty and open communication were listed by most respondents as essential. As well, it is important that responsibilities be clearly articulated with an understanding of who is taking a lead role in the transition process. Clients suffer when not all information has been shared, and when the teams have different understandings of the same person. The use of client-based, formal contracts with

¹⁹ Slow stream rehabilitation was shown to be effective in achieving community placements for long-stay dual diagnosis patients and that faster progress towards discharge could be achieved through individualized programs and special training for staff (Treiman et al, 2002).

this information, along with clear protocols indicating when responsibilities would shift, is very helpful to the process. For example, CAMH's Dual Diagnosis program uses contracts to clarify service expectations for both inpatient and outpatient services. The agreement includes the individual's goals for the service along with what the program will be offering, and is jointly signed by the client, substitute decision maker (SDM), community agencies, and the Dual Diagnosis program.

Key ingredients for dual diagnosis high support housing

In 2007, the *Community Networks of Specialized Care* were created, funded by MCSS and in partnership with mental health providers. The Networks were created to ensure a system that is accessible, co-ordinated, integrated and accountable. With new funds provided through MCSS for specialized residential care, some of the networks invested these in transitional beds, as a step down from hospital.²⁰

Across the province, these homes have a high staff to client ratio, as high as 1:1, with staff that are awake overnight. Staff may be developmental service workers with a college degree, social service or child and youth workers, and/or individuals with undergraduate psychology degrees. Most also have staff with a background in behavioural science technology (i.e., behaviour therapists). Agencies have tended to provide additional specialized training to their staff, and those who are hired typically have experience working with dual diagnosis clients.

Most of the homes also have access to specialized clinicians (e.g., psychology, psychiatry, nursing, behaviour therapy, and/or occupational therapy), although this varies by region. In Kingston, the agency that operates the "treatment home" has all of these clinical disciplines on staff, allowing for easy access. They are also linked to the university so that many student trainees obtain experience working under supervision. *Kerry's Place* established a model whereby clinics are held monthly with psychiatry and psychology providing streamlined access to an interdisciplinary assessment within a short timeframe. Other homes reported having formal agreements with dual diagnosis tertiary hospital programs, but fewer relationships and more difficulties with local hospitals and emergency rooms. Several have worked closely with community liaison officers (police) to create client specific crisis plans and supports. Mobile crisis supports are used when available; and similarly, ACT teams can be a useful resource when staff are properly trained. Homes tend to experience greater difficulty in accessing community mental health services.

Key ingredients for risk management

Several safety measures have been built into the home environments of these clients to deal with aggression, elopement, and other issues. Video surveillance is common, as are keys for the bedrooms and external door and window alarms or buzzers. Some homes make use of two-way radios, while cell phones and on-call emergency systems are also common. Items which could be used as weapons are bolted to walls and windows are covered in lexan to prevent shattering. Some rooms may have padding to keep individuals prone to self-injury safe. One agency

²⁰ In Britain, extended care residences have been used to facilitate the transition from hospital to community. Average length of stay is 2 years.

described the importance of “safe areas” where clients can be watched by staff, with staff and other clients out of harm’s way if necessary (i.e., “reverse confinement”).

All houses in the developmental sector share the same approach to managing and preventing crises: non-violent crisis intervention. This means that staff in each of these homes receive the same training and have the same restrictions around how physical they can be in a crisis. Similarly, all staff have access to behaviour therapists who work with the home to develop personalized behaviour support and crisis plans that dictate how to intervene at each stage of crisis development. Sometimes referred to as “behaviour protocols”, these documents identify signs of distress, anxiety, and agitation with appropriate responses. These can include administration of medication and calling for additional clinical assistance like mobile crisis, police, or emergency room support.

Some of these homes are less than 18 months old and so it is difficult to comment on typical length of stay. Some individuals have stayed on for more than a year, while others with more challenging issues have stayed up to four years. Still others, with the right supports and a responsive community agency who can adapt the “treatment bed” model, can move down a level in support and succeed in the community. However, more evaluation of these individuals is required. It is clear that some of those who use the specialized beds may not improve to the point that they no longer need the bed. They may become stabilized so that they can live safely and without crisis, but this stability would be threatened if the supports were then withdrawn. The system issue then becomes one of how to build capacity for moving clients through to long-term, high support environments.

B) Geriatric mental health

Transitioning ALC/long-stay geriatric mental health clients from hospital to community is viewed as “extremely hard work”. With high demand on limited resources in long-term care (LTC) homes, combined with a shortage of specialized care units, transitional, and other forms high support community housing for geriatric clients, the challenge is immense. Contributing to the problem is the large number of geriatric beds that were taken out of the system during the downsizing of former provincial psychiatric hospitals. These beds were not replaced in the community with high support housing, resulting in inappropriate placements such as in LTC facilities.

i. Findings from the literature

A recent systematic review of the evidence on the effectiveness of geriatric mental health services, defined as multidisciplinary, comprehensive, integrated service delivery to a defined catchment area, provides perspective on the evidence base in this area (Health Evidence Network, WHO, 2004). The authors conclude that there is good evidence to support multidisciplinary individualized community services, case management in the community, and liaison in residential care. The integration of acute hospital and community care has also shown improved outcomes following discharge.

In weighing the evidence from comparison studies of hospital and community residences, the authors were unable to determine whether there are particular patients who require long-term

hospitalization. Studies showed that community residences appeared to offer better quality care than hospitals. It was found that people with schizophrenia tended to stabilize faster in the community and had higher quality of life, more social contacts and more privacy. Families also expressed higher rates of satisfaction. The authors conclude that purpose-built community residential facilities work better for less dependent patients with dementia and schizophrenia, but it is not clear whether they are well-suited to aggressive patients with severe behavioural disturbances.

Overall, there is a lack of cost-effectiveness evidence related to different service delivery models, and this was identified as an important need in the area.

ii. Findings from the focus groups

Clients

Participants noted that people are living longer and presenting with more co-morbidities and complex mental health problems, which result in longer hospital stays. Given pressures on hospital beds, there is increasing demand for appropriate geriatric community-based housing and mental health services and supports. It was specifically noted that geriatric patients present significant ALC and discharge problems for acute care hospitals. Clients who demonstrate hoarding, wandering, general aggression, and/or sexually inappropriate behaviour are particularly challenging to place.

Service and system barriers

The transitioning of geriatric clients with complex mental health needs into the community was seen to be complicated by the presence of several service-level barriers. First, staff of LTC homes are not specifically trained in the management of mental health and behavioural problems. Staffing ratios in LTC homes also need to be enhanced to manage long-stay clients. Participants reported that many geriatric clients do not need LTC and would do well in community residences with on-site nursing care, personal support workers, shared care, and staff trained in mental health. The problem is that there are very few of these homes.

LTC homes are often reluctant to accept potential geriatric mental health referrals because they have not had sufficient back-up from specialized services in the past and may have had difficulty in accessing tertiary care beds when needed. CCAC's do not have a specific mental health mandate and may, although not always, offer limited support to mental health geriatric clients. The lack of ongoing collaboration between sectors (i.e., mental health and long-term care) creates a system-level barrier. Finally, mental health providers indicated that the lack of an appeal process when a LTC home turns down a referral is a serious impediment.

Participants spoke to a perceived lack of flexibility in the LTC sector which hampers successful hospital discharges by not allowing sufficient time for preparation of the client. Participants advocated for more flexibility in the process and new ways for the two to work together.

One informant stressed that the two sectors are not integrated in their thinking about seniors with mental health problems. Similar to dual diagnosis clients, this group can either be overlooked or provided with services that are poorly adapted to their particular needs. From the perspective of the seniors' care sector, mental health often means dementia, including Alzheimer's, but not schizophrenia. Conversely, mental health services can overlook seniors' needs for personal care and support around activities of daily living. Another issue concerns the eligibility age for seniors services. Sixty-five is viewed by some as being too high and needing to be lowered to 55 or even less for those with medical, long-term care needs.

The CCAC role seems to be in the process of expanding around seniors with mental health issues. It is anticipated that this role will vary across LHIN's as each one will decide the extent to which it will get involved in supportive housing (e.g., bundling referrals and case management, or service coordination beyond LTC for seniors with mental health issues). LHIN's have also been closely tied into developing strategies for reducing ALC days. One example provided was how the Toronto LHIN used monies dedicated to aging at home to create more seniors mental health housing and supports, and linked those beds to acute care hospitals to reduce ALC numbers.

iii. Approaches to transitioning geriatric clients: Ontario examples

The experiences of service providers in Ontario can inform the process of transitioning geriatric clients from the hospital to the community. A "whole system" approach, in which a range of service options was available, was frequently mentioned as the preferred option. This includes the provision of:

- transitional beds, LTC beds, and community beds
- psycho-geriatric consultation teams
- specialized geriatric mental health outreach teams that focus on individuals with aggressive behaviour (i.e., to be strengthened and increased in number from existing resources)
- specialized training for the staff of LTC homes through *Psychiatric Resource Consultants*

The process starts with individualized discharge planning and collaboration between the hospital and the receiving agency. The generic transitioning processes and strategies presented earlier apply here as well.

Models of community housing and specialized care

Transitional Housing Model: The geriatric unit at CAMH and a large supportive housing provider, LOFT, teamed up to develop transitional housing, termed the *Stepping Stone Project*, for 12 seniors with mental health and addictions problems. Length of stay is six months and residents can move on to permanent housing within the same facility or in the community. The transitional housing enables the residents to "try out" community living to see how they adjust, thus providing a necessary step in preparing them for more independent living. The program focuses on activities of daily living and rehabilitation. The hospital offers psychiatric assessment, occupational therapy, and nursing, while the housing has 24/7 staffing, a personal support

worker, and two transitional housing workers. There is also a “take-back” agreement in place where the hospital will readmit the client if necessary.

Specialized Care Units: A “whole system” approach was taken by St. Joseph’s Health Care in London. *Discharge with a Difference* describes an evaluation of the relocation of long-stay, stable geriatric psychiatry patients to long-term community care through the formation of a special care unit in a LTC home. Three critical elements comprise the approach:

- A consulting psychiatrist
- A geriatric mental health outreach and liaison team that provides 24/7 support and consultation to the home
- Creation of a 22-bed special care unit within a LTC home, featuring enhanced safety and security provisions such as unbreakable window glass, no electrical outlets and velcro curtains

This highly successful project emphasized the importance of a pre-planning process with staff, clients and family members to provide adequate preparation and ready access to tertiary resources for the LTC home. Facilitative processes identified by the evaluation team supporting the transition were:

- An emphasis on individualized care and solutions
- Good community information sharing
- Regular visits to the home by the discharge liaison team and 24/7 access to the team

Overall evaluation results showed a low recidivism rate of relocated residents to inpatient, emergency, and outpatient services, and a decline in the use of tertiary consultation and support services after only a few months. This reflected an increased confidence in the staff of the home in their ability to manage the new clientele.

Specialized Behavioural Units: This approach is needed for a sub-population of people 65 or older with a diagnosis of dementia or a secondary diagnosis of a serious mental illness with associated severe behavioural problems (e.g., aggression or agitation). It is estimated that this represents 7-10% of the long-term care population (*Report of the Task-Group Defining Sub-Populations in Long Term Care Facilities, 1998*). While these units exist in some parts of the province, including London, Toronto, Ottawa, and Niagara, there is an overall shortage. Central East Region (2007) recently developed a proposal for a specialized behavioural unit. These units have higher staff to resident ratios, private rooms, special security features, and multidisciplinary teams, and are situated in home-like settings consisting of approximately 10 residents. Staff are highly trained in managing aggressive behaviours.

The goals of these units, as articulated in the Central East Region proposal (2007), are to provide safe and appropriate care, prevent admissions to hospital, reduce high-risk situations in LTC homes and, ultimately, to transfer clients to LTC homes when the specialized setting is no longer needed. Linkages across the system need to be in place to facilitate movement of residents to more appropriate settings when appropriate. The proposal argued that the addition of specialized units would improve system efficiency and enhance the continuum of care for these individuals whose needs are not currently being well met.

Consultation services: Multidisciplinary psycho-geriatric teams

In Ontario in 2005, specialized health accord funds provided for additional multidisciplinary psycho-geriatric teams. In Toronto, funding was sufficient to enable each LTC home to be attached to a team. The objectives of the funding were to increase the capacity of LTC staff to manage difficult behaviours and, therefore, for the homes to accept more challenging clients. An evaluation of this initiative was carried out by CAMH (Fischer et al., 2009). The clients referred for consultation suffered from agitation, aggression and depression. The interventions offered by the teams were both pharmacological and non-pharmacological, including staff training, structured activities, environmental changes, sensory stimulation, and psychosocial interventions. The evaluation found that both types of recommended interventions were taken up by LTC staff, but that pharmacological interventions were more widely used.

The authors conclude that to realize the full effect of these services, teams need improved access to tertiary care beds and enhanced frontline staffing.²¹ Also, from a “whole system” approach, the evaluation concluded that outreach teams need to make their services available to emergency room hospital staff. Finally, teams with multidisciplinary support tend to be more effective, and the provision of staff training in the homes comprises a necessary part of the consultative service.

C) Concurrent Disorders:

“We all need to have a go at this.”

i. Findings from the literature

Ongoing support in the community, through supportive housing or other initiatives, constitutes an essential component of a comprehensive care system for individuals with concurrent substance use and mental disorders (Somers et al., 2007). Due to the nature of their conditions, individuals with concurrent disorders have increased risk of homelessness and repeated hospitalizations, as well as experiencing specific barriers to stable housing (Health Canada, 2002; Somers et al., 2007; see also the following section, *Findings from the focus groups*). Supportive housing models need to be flexible, with options for individualizing supports and services for clients as needed, and with minimal barriers to access (Somers et al., 2007).

Two housing models have been written about extensively for at-risk individuals with concurrent disorders: *housing first*, which is a permanent housing approach, and *integrated residential treatment*. The *housing first* model assumes that getting homeless at-risk people into housing is the first step towards making progress with substance use. While most of the research on *housing first* projects is based on scattered sites with mobile supports, one recent study looked at a large inner-city shared housing program that uses a *housing first* approach and harm reduction framework (Fred Victor Centre and Jim Ward Associates, 2009). The study concluded that this type of facility requires intensive and highly specialized 24/7 supports. Further, while shared

²¹ One individual expanded on this statement to say that a “comprehensive basket of services” is needed that includes access to specialized assessment and treatment in both acute and tertiary care. The tertiary role is to differentiate the responsive behaviours type dementia person who could be channelled to LTC homes or to provide stabilizing treatment interventions and care plans with expected transfer to behaviour support units in LTC homes.

accommodation can be effective for some, others require private accommodation. In a congregate living environment, in-house supports are needed that focus on life skills, conflict resolution, and space sharing.

In a recent longitudinal study, outcomes associated with *integrated residential treatment* were promising, with declines in both alcohol and drug use after 18 months (Davis et al., 2006). The program consisted of simultaneous treatment of mental health and the substance use problems by a single multidisciplinary team. Treatment was stage-based, using motivational counselling combined with residential services and a skilled ACT team. Clients live in apartments and receive frequent visits by the team. The authors conclude that while residential treatment is complex and expensive, it can be effective in maintaining stable remission. Many studies of residential treatment report mixed results, and those reporting positive results attribute them to unlimited lengths of stay and the adoption of a collaborative, recovery-oriented, flexible, and non-confrontational approach (Davis et al., 2006).

Given the chronic nature of substance use disorders and fluctuating motivation for abstinence, approaches to service provision for this sub-population need to be proactive and longitudinal. One specific example that has met with success involves ongoing monitoring and early re-intervention services for those who have been previously linked with treatment and are now living in the community (Rush et al., 2008). The *Recovery Monitoring Check-up* (RCM) model, developed and evaluated in Chicago (IL), recognizes the chronicity of substance problems and offers continued support to people following discharge from an active phase of substance abuse treatment (Dennis et al., 2003). Providers “check-in” with clients on a quarterly basis and assist with reconnecting those in need with services. Although not designed specifically for those with concurrent disorders, recent work supports the effectiveness of the RMC approach with this sub-population, in terms of reduced rates of relapse to substance use and unmet needs for care (Rush et al., 2008). Those involved in developing and evaluating the model suggest that its success stems from reducing barriers to treatment re-entry and reinforcing with clients the availability of post-treatment support in the community.

ii. Findings from the focus groups

“Community continuity is an issue for this population.”

Clients

Individuals with concurrent disorders represent a large number of ALC days in acute care hospitals overall, but they tend to cluster at the short end of duration (i.e., 1-7 ALC days). Key informants identified particular issues associated with longer stays, but generally did not view this group as especially problematic. One participant noted: “they’re more of an in and out problem.” In particular, these clients are at high risk for losing their housing.

Two sub-groups of individuals with concurrent disorders, differentiated in terms of age, were identified as posing placement issues. First, young people who use substances are seen as a difficult to place due to perceived and real risks related to their behaviours (e.g., their friends may bring illicit drugs to the residence, or the clients themselves may be selling drugs or

engaging in sex trade work). More generally, they may struggle with housing set-ups in the community. On the other hand, there is an overall lack of treatment options for older people with concurrent disorders.

“The lack of tolerance of the types of issues unique to this group is an issue.”

Services

The concurrent disorders sub-population presents “one more layer of complexity” and, because of this, they “slide into the gap”. Participants seemed to agree that people with concurrent disorders need the same services as others, the only difference being that the service providers need to have the corresponding skills and knowledge. They noted that consistent screening of people for substance use is not occurring in mental health programs. The lack of knowledge around concurrent disorders hampers treatment planning. The problem is compounded by the different perspectives, languages, and tools used by mental health and addiction treatment providers. As one informant said, “we need a concurrent disorders program for the province,” to achieve consistency and improved response to people with these issues.

Participants thought that harm reduction approaches are important, but not always accepted by provider communities. This is an issue as the recurring nature of the problem necessarily involves relapse. When this happens, residential services frequently force the client to leave and, therefore, start over. Services need to be designed to give clients multiple opportunities to improve (e.g., “forgivable housing”).

Finally, participants advocated for specialized residential services in regions where there are sufficient numbers of clients with concurrent disorders who could benefit. If the numbers are too small, the suggestion was that they be integrated with the general population. People with concurrent disorders are best housed in environments where others are not using substances. Participants observed that there is a critical shortage of this type of housing. Yet not all clients can tolerate these restrictions and as one participant said, “what we need are wet, damp and dry housing to accommodate them all.” ACT, case management, and psychiatric follow-up, all with concurrent disorders training, are considered important services that are currently in short-supply.

V Implications for Policy, System, Services and Funding

“More creativity and more resources...”

The problem of ALC/long-stay mental health patients remaining in beds when they could be served in the community is multi-dimensional and requires an integrated “whole system” approach to its resolution. The ALC/long-stay population is heterogeneous and presents with highly complex needs that are not being adequately addressed in the current system. This results in either unnecessarily long stays in hospital or under-servicing in the community. The latter frequently leads to relapse and hospitalization. Achieving the appropriate level of care for this

population is the ultimate goal for any initiative designed to address this problem. As noted, there has been a considerable shift in policy and attention toward ALC/long-stay patients and, in particular, geriatric patients. This report puts a spotlight on the large contribution made by mental health clients to ALC/long-stay in Ontario and builds on current knowledge about effective transitioning and discharge processes.

The scope of the secondary data analysis and stakeholder consultations was necessarily high-level and broad.²² In the consultations, we were interested in learning about what works in the transitioning and placement of long-stay clients, how providers have adapted their services to serve this population, and what additional resources are required to improve response. We found considerable consistency in the responses of focus group participants on these questions. Key informant interviews also aligned well with the focus group findings, providing additional context. Finally, the secondary data analysis confirms that ALC/long-stay clients represent a large portion of hospital stays, making them a significant target population for those concerned with the problem.

What we have gained with this project overall is a “big picture” of the scope of the problem, including who are the clients, what effective strategies are being used, and what needs to be done. We found great commonality in the challenges identified by participants: the shortage of model high support housing; limited supply of community mental health services; low accessibility to primary care and psychiatric follow-up; need for improvements in assessment, discharge planning and referral processes; and co-ordination challenges. Our findings resonate with previous investigations into ALC issues and problems (*Appropriate level of care: a patient flow, system integration, capacity solution, 2006*).

We found high levels of creativity, commitment and innovation across the province. Many excellent examples of system collaboration both cross-sectoral and cross-services (i.e., hospital and community mental health) were identified. We also noted that many LHIN’s and their regions are involved in detailed planning exercises to see exactly what types of and how many housing and mental health services they would need to meet demand. We applaud such efforts. Overall, there is a very broad range of approaches and strategies being applied across the province, and we acknowledge that there is no one solution that will solve the problem of ALC/long-stay mental health clients. Many of these local solutions are a function of particular relationships and resources and not necessarily templates for the province as a whole.

What we can offer from the vast amount of data collected is an extraction of principles and approaches that can be combined into a framework to guide policy, planning, service delivery and funding decisions for this population. Such a framework is necessary because the extremely high, complex needs of this population are a poor fit with existing housing and community mental health resources. This results in problems of length of stay in hospital and discharge to

²² It should be noted that the scope of this project is limited to people who are captured by the provincial administrative datasets. We acknowledge that there is a subset of homeless individuals and geriatric patients with severe behavioural problems who do not enter the hospital system for various reasons and yet share many of the same characteristics of the ALC/long-stay clients profiled here. These individuals would also require similar resources. Although this project was not meant to be a needs assessment for services, we should highlight that the numbers reported here are an underestimate of the scope of the problem.

community. There is ample evidence to draw from in the literature, as well as in practice, to show how effective transitioning can be done.

We conclude with the point that only an integrated, “whole system” approach is sufficient to deal with the multi-dimensional nature of the ALC/long-stay problem. Implications of the present work highlight a range of interventions and strategies that, if implemented, may be expected to decrease mental health ALC/long-stay days. They reflect a combination of approaches that could be developed both within existing resources and with additional resources. This is consistent with the Expert Panel’s conclusion that reduction of ALC days will require significant investments and improved integration (*Appropriate level of care: a patient flow, system integration, capacity solution, 2006*).

A) Policy Implications

“Programs aren’t designed to work together.”

1. A policy framework for ALC/long-stay complex mental health clients that specifically addresses their needs for high support housing within a continuum of housing alternatives and specially tailored mental health services and supports would facilitate their transitioning and discharge from hospital to community. Further, to reflect the complex, clinical needs of the clientele these services would go beyond the current range of community mental health services (i.e., ACT, case management, crisis intervention). The policy framework would include for provisions for access to specialized multidisciplinary teams for high support housing clients and staff that could either be linked directly with the housing or de-linked but easily accessible. The particular staff skills and knowledge required to work effectively with this population would be clearly articulated along with guidelines for the formation of collaborative relationships between hospitals, high support housing services, and community mental health services and supports.
2. Efforts to further integrate MOHLTC mental health and addictions policy for people with concurrent disorders would be beneficial.

B) System Implications: Improving System Performance

1. LHIN leadership and/or support would be helpful in keeping the spotlight on the problem of ALC/long-stay mental health clients and the special sub-populations discussed here. There are multiple possible options for this, including instituting ALC committees at the LHIN-level for the purpose of convening regional mental health and addictions planning tables periodically for system-level planning, information sharing, problem-solving partnership development, and management of urgent issues surrounding ALC/long-stay mental health clients.
2. LHIN leadership and/or support would be helpful in providing oversight regarding the setting of explicit goals for discharge of long-stay mental health clients, service system access, and collaborative hospital and community treatment. The LHIN role could be extended to include system monitoring and feedback.

3. Clarification around the role of CCAC's in mental health in two areas would be helpful: the delivery of mental health services and the provision of medical services to mental health clients.
4. At a district or local level, hospital and community mental health providers could consider developing "difficult to serve" or "problem solving" committees that come together for joint case planning and follow-up of very complex cases. Such committees can become involved at any stage in the process, including discharge planning. This is mandated in the dual diagnosis guidelines and could be expanded to all mental health and addiction clients.

C) Service implications: Service Delivery and Development

“Discharge of legacy patients is an interdependent process: requires reconfiguring new services - transitional high support homes, access to specialized and continued monitoring of the system.”

1. The transitional discharge model is a collaborative process involving hospital, high support housing and community providers and implemented at the tertiary care level where there remain significant numbers of "legacy" patients and high numbers of newer long-stay, complex clients. The benefits of this model are well documented and it could be considered a best practice.
2. Peer support plays a pivotal role in the transitioning process, both in preparing clients to leave hospital and in assisting in their adaptation to the community. It should be viewed as an integral feature of the transitional process.
3. The important role of family in supporting the individual and acting as an ally to the transitioning process needs to be respected by hospital and community mental health housing staff.
4. Both tertiary and acute care hospitals, in conjunction with their community mental health partners, could take further steps towards building successful collaborative relationships. Transitioning is facilitated when hospitals incorporate the following key elements of successful community transitioning: providing post-discharge follow-up and monitoring, offering psychiatric back-up in the community, instituting quick readmission policies (e.g., "take back agreements" or by-pass arrangements), using discharge checklists, holding community rounds in hospital, placing community mental health staff inside the hospital, and providing access to specialized knowledge and expertise.
5. A continuum of specialized multidisciplinary teams is needed to deliver a range of specialized service to clients and staff at various points in the discharge, transition and community relocation processes enhances the transitioning process. There are various models for delivering this service and it is assumed that model selection will be based on client needs and geographic characteristics. Specialized multidisciplinary teams that span the boundary between hospital and community are effective agents in the discharge and transitioning processes and should be considered where the numbers of ALC/long-stay clients warrant. These are typically located within the hospital. Their role is to facilitate discharge, not to provide ongoing, long-term support.

Access to ongoing specialized multi-disciplinary staff is critical for community providers who are housing and working with high needs, complex clients. Many of these clients need long-term follow-up and support. Tertiary-level outreach teams for complex mental health clients are demonstrated practices that offer assessment, consultation, and education. They are valuable instruments for building community capacity and confidence when they include an explicit staff role for system planning, knowledge exchange and education. Another suggested approach is to develop mobile multidisciplinary teams that are attached to high support housing to ensure that the resource is effectively linked and available to residents. Access to mobile multi-disciplinary crisis teams play an important role in averting hospitalization and keeping people in the community.

6. Increasing the supply of high support housing, including both transitional and permanent high support homes, and placing a special focus on the needs of complex ALC/long-stay mental health clients will address a critical need. This housing requires adequate funding for it to provide appropriate levels of and mix of staffing (e.g. personal support workers for geriatric mental health clients). It should reflect the characteristics described in model high support housing and programming (see section on *High support housing*). High support housing needs to be situated within a full continuum of housing alternatives to achieve greatest effect.

7. Given the high medical needs of this population, high support housing services require ongoing linkages to primary care, including both physicians and nurses, and other staff who are experts in chronic disease management. Further work with CCAC's is needed to ensure that mental health clients have access to required medical services.

8. A health human resources strategy is needed to equip high support housing and community mental health services staff with the requisite skills (see section on *Staff education and training*), as well as the knowledge needed to work effectively with this population. Tertiary-level training, education and consultation all play a role in this. ACT, case management and intensive case management services need to be tailored to the special needs of ALC/long-stay mental health clients, with resources developed specifically for geriatric and dual diagnosis clients.

9. The prevalence of concurrent disorders is high enough to warrant all staff working with the ALC/long-stay population to have concurrent disorders training with attention to assessment, harm reduction, and relapse prevention strategies. This would involve a training strategy with funding attached. Regional mental health and addictions networks and planning tables play an important role in strategy development and CAMH is a significant provincial training resource.

10. LHINs and MCSS must continue to work together to develop appropriately supported residential placements for people with dual diagnosis. Staffing with expertise both in developmental disability and mental health rehabilitation is required. Both community and hospital teams need to be able to provide these supports required for this population.

11. For geriatric clients with complex mental health issues, a “comprehensive basket of services” is needed that includes access to specialized assessment and treatment in both acute and tertiary care as well as access to appropriate levels of residential and community care would be

beneficial. More highly-trained multidisciplinary specialized outreach teams would help to address the demand and improve access to service for clients in LTC homes and high support housing services. These teams are essential for building capacity in the sector and for aligning seniors' services with mental health services.

D) Funding Implications

1. The establishment of a funding mechanism for the administration of flexible funds that follow the client for the purpose of purchasing needed services would enable a more individualized approach to community care. Earmarking these funds for smaller items that would facilitate the transitioning process (e.g., purchasing a service on a time-limited basis) is an approach that has been used with some success. In addition, allowance of greater flexibility in the use of mental health program funds would enable programs to shift funds to where they would provide the most benefit.

2. Enhancement funds are needed for high support housing services to increase staffing levels and the range of essential in-house disciplines, in particular personal support workers. The establishment of specialized multidisciplinary teams requires additional funding. Given that a large portion of the housing stock is older, housing funds are needed for improvements and to increase accessibility for a population with high medical needs.

3. Additional funds are needed to augment the supply of high support housing and increase access.

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Appendix A: Project Advisory Panels (Phases 1 & 2)

Phase 1 Project Advisory Panel

Name	Title/Position
Lynn Martin	Professor, Master of Public Health (MPH) Program
Karin Carmichael	Program Administrative Director, Providence Care
Nancy Read	Program Director, Mental Health Services, St. Michael's Hospital
Peggie Willett	Director of Decision Support, Centre for Addiction and Mental Health (CAMH)
Cyndy Barrow	Clinical Manager, Mental Health Services, Niagara Health System
Marilyn Dakers-Hayward	Director of Psychiatry/Department Manager, McMaster University

Phase 2 Project Advisory Panel

Name	Title/Position
Mohammad Badsha	Director of Program Development and Community Integration Reconnect Mental Health Services
Elly Harder	Crisis systems coordinator, Waterloo-Wellington c/o Trellis Mental Health & Developmental Services
Karin Carmichael	Program Administrative Director, Providence Care
Peggie Willett	Director of Decision Support, Centre for Addiction and Mental Health (CAMH)
Kristine Diaz	Integrated Vice President (acting) Mental Health Services, St. Joseph's Health Care London/London Health Sciences Centre
Nancy Read	Program Director, Mental Health Services, St. Michael's Hospital
Heather Scott	Executive Director, Niagara Health System
Carol Lang	Policy Analyst, Mental Health and Addictions Unit, Health Program Policy and Standards Branch, MOHLTC
Pam Carter	Coordinator, Central East Network of Specialized Care
Tanya Weber-Kinch	Ministry of Community and Social Services (MCSS)
Dawn Maziak	County Planner, Erie St. Clair LHIN
Susan Morris	Clinical Director, Centre for Addiction and Mental Health (CAMH)
Sandra Brockus	Inpatient Manager, Centre for Addiction and Mental Health (CAMH)
Gail Grant	RSW Manager Psycho geriatric Resource Consultant, Peterborough Regional Health Centre
Linda Sibley	Executive Director, Addiction Services of Thames Valley

Appendix B: Key Informant Interviews

Name	Title/Position
Mohammed Badsha	Director of Program Development and Community Integration Reconnect Mental Health Services
David Colgan	Senior Director, Central West LHIN
Nazira Jaffer	Senior Consultant, Central West LHIN
Sandy Stockman	LOFT, Providence Care, Mental Health Services
Vicki Huen	Executive Director, Frontenac Community Mental Health Services
Ken Balderson □	Staff Psychiatrist, St. Michael's Hospital
Jane Sippell □	Director, Mental Health and Addictions Program, Sault Area Hospital
Jim McMinn	Director of Senior's services, LOFT
Gabriella Golea	Administrative Director, Geriatric Mental Health Program, Centre for Additional and Mental Health (CAMH)
Karin Carmichael	Program Administrative Director, Providence Care

Appendix C: Tables

<u>Individuals with MH/A ALC or long-stays: 2007/08</u> ²³		
	# individuals	% of TOTAL
TOTAL with MH/A ALC or long-stay	5,189	100.0
Tertiary hospital designated beds	1,015	19.6 ²⁴
65 years or older	~ 80 ²⁵	
male	647	
With concurrent disorders	246	
With dual diagnoses	~185	
Acute care hospital designated beds	3,209	61.8
65 years or older	396	
male	1,795	
With concurrent disorders	744	
With dual diagnoses	385	

²³ Excluding individuals with dementia.

²⁴ Totals do not equal 100 percent for the following reasons:

- some ALC or long-stays occurred in non-designated beds -- i.e., were captured in DAD
- some ALC stays captured in OMHRS did not record the number of ALC days and were therefore excluded from the analysis

Also, note that the individuals counted for Tertiary and Acute care hospitals are not necessarily mutually exclusive. The number of ALC or long-stays exceeded the number of individuals (5520 stays vs 5189 individuals) meaning that some individuals had more than one during 2007/08.

²⁵ Sums preceded by a tilde (~) are rounded because they include small, unreportable cells.

<u>Hospital Stays with MH/A ALC or long-stays: 2007/08²⁶</u>		
	# hospital stays	% of TOTAL
TOTAL with MH/A ALC or long-stay	5,520	100.0
Tertiary hospital designated beds	1,107	20.1 ²⁷
With schizophrenia/psychotic disorders	636	
With mood disorders	182	
With concurrent disorders	265	
With dual diagnoses	~200 ²⁸	
With physical illness	443	
Acute care hospital designated beds	3,402	61.6
With schizophrenia/psychotic disorders	1,798	
With mood disorders	933	
With concurrent disorders	812	
With dual diagnoses	425	
With physical illness	1,148	

²⁶ Excluding individuals with dementia.

²⁷ Totals do not equal 100 percent for the following reasons:

- some ALC or long-stays occurred in non-designated beds -- i.e., were captured in DAD
- some ALC stays captured in OMHRS did not record the number of ALC days and were therefore excluded from the analysis

Also, note that the individuals counted for Tertiary and Acute care hospitals are not necessarily mutually exclusive. The number of ALC or long-stays exceeded the number of individuals (5520 stays vs 5189 individuals) meaning that some individuals had more than one during 2007/08.

²⁸ Sums preceded by a tilde (~) are rounded because they include small, unreportable cells.

Hospital Stays with MH/A ALC or long-stays: 2007/08 ²⁹			
Number of ALC/long-stay days	Mean LOS ³⁰ (Range)	% previously hospitalized ³¹ (MH/A reason)	% previously hospitalized ³¹ (any reason)
Tertiary hospital designated beds			
None	26 (1-90)	20.4	26.1
< 1 week (1-6 days)	65 (1-132)	33.3	42.4
< 2 weeks (7-13 days)	76 (7-103)	34.4	44.3
< 1 month (14-29 days)	86 (14-119)	36.2	41.9
< 3 months (30-89 days)	137 (33-178)	45.5	49.0
90-plus	379 (105-817)	40.5	41.4
Not yet discharged ³²	501 (94-910)	32.8	34.3
Acute care hospital designated beds			
None	12 (1-90)	17.6	23.3
1-6 (< 1 week)	37 (1-676)	23.1	30.0
7-13 (< 2 weeks)	55 (7-479)	24.6	33.2
14-29 (< 1 month)	72 (14-622)	29.9	36.2
30-89 (< 3 months)	118 (31-597)	34.2	39.0
90-plus	358 (92-834)	48.6	56.1
Not yet discharged ³²	479 (91-910)	32.2	43.0

²⁹ Excluding individuals with dementia.

³⁰ Includes all days in the inpatient stay whether ALC/long-stay or not.

³¹ Where discharge from previous hospital stay was within 30 days of admission for current hospital stay.

³² These are on-going stays where the LOS is greater than 90 days. Because the individual has not been discharged, the actual number of ALC/long-stay days cannot yet be determined.

Appendix D: Details on the Secondary Data Analysis

The secondary analysis used provincial administrative data from the most recently available fiscal year: 2007-08. The primary data source was the 2008/09 *Ontario Mental Health Reporting System* (OMHRS), which houses data from the RAI-MH standardized assessment. Data cover all discharges and ongoing stays occurring in designated mental health beds in hospitals across the province. They provided the diagnostic information, as well as the demographic, clinical, and behavioural factors (see Table 1 below for a list of specific variables). Additional datasources were accessed to provide background information, define specialized sub-populations, and describe system outcomes after discharge. Specifically, the *Discharge Abstract Database* (DAD) contains information on inpatient discharges from non-designated hospital beds; the *Ontario Health Insurance Plan* (OHIP) data include all claims submitted by fee-for-service physicians; and the *National Ambulatory Care Reporting System* (NACRS) includes discharge information for all emergency department visits in the province.

The following definitions were used to abstract and analyse the data:

Event: Encompasses to both hospital discharges and ongoing stays

Patient day: Refers to the total number of days that an event has lasted (i.e., a hospital stay lasting 10 days will count as one event and 10 patient days).

Mental Health/Addiction (MH/A): All events recorded in the OMHRS data were considered MH/A.³³ Events recorded in the DAD were classified as MH/A if they had a most responsible diagnosis with an ICD-10 code of F00 to F99 inclusive.

ALC days: Refers to the total number of days in hospital after the primary physician recorded that the patient no longer needed acute hospital care (based on the definition used by the *Canadian Institute for Health Information*)

Long-stay days: For events that have no ALC days, refers to the total number of days in hospital past Day 90 (i.e., three months)

Lengthy ALC/long-stay events: Refers to events with 90+ ALC days or events with 90+ long-stay days (i.e., stays of 180 days or more)

³³ All cases in this database were considered to be MH/A. In 2008/09, diagnosis was not a mandatory field for hospitalizations of less than 72 hours, such that there were a large number of missing diagnoses and this field could not be used to verify MH/A status among records. There will be a very small percent of non-MH/A cases admitted to designated beds because of bed availability (Brenda Antliff, MOHLTC, personal communication, 2008); however, these should be too small to affect the results reported here.

Three special sub-populations of clients were also identified for specific focus in sub-analyses.

Dual diagnosis: Cases with...

- RAI-MH item Q3 = 1, or one or more hospital event, emergency room visit, or OHIP visit associated with a developmental disorder diagnosis in any diagnostic field (ICD-10: F70-F79; F84; Q86.0, Q90; OHIP diagnostic code: 319)
- AND one or more hospital event, emergency room visit, or OHIP visit associated with a most responsible or main diagnosis of mental disorder (excluding developmental disorders; ICD9: 295.0-295.9, 297.0-297.3, 297.8, 297.9, 298.3, 298.4, 298.8, 298.9, 296.0-296.9, 298.0, 300.4, 301.1, 311, 300.0, 300.2, 300.3, 308.3, 308.9, 307.1, 307.5, 301.0, 301.2-301.9, 317, 318.0-318.2, 319, 299.0, 299.1, 299.8, 330.8; ICD10: F20-F43, F50, F60-F62, F70-F79, F84; OHIP diagnostic code: 290, 295-302, 306-319)

Geriatric mental health clients (i.e. Cases of persons 65 years of age and over with a most responsible diagnosis of mental or substance-related disorder and no evidence of dementia):

Concurrent disorder: Cases with...

- One or more hospital event, emergency room visit, or OHIP visit associated with a diagnosis of substance use disorder in any diagnostic field (ICD9: 291.0-291.3, 291.8-292.2, 292.8, 292.9, 294.0, 303, 304.0- 305.9, 312.3; ICD10: F10-F19, F63.0; DSM-IV: 291-292, 303-305, 312.31; OHIP diagnostic code: 291-292, 303-305)
- AND at least one hospital event, emergency room visit, or OHIP visit associated with a most responsible or main diagnosis of mental disorder (excluding substance use disorders; see *Dual diagnosis* definition above for list of specific codes)

Finally, clients with dementia were identified for exclusion, in accordance with the primary focus on mental disorders.

Dementia: Cases with one or more hospital events or emergency room visits associated with a diagnosis of dementia in any diagnostic field (ICD-10: F00-F03; DSM-IV: 290, 294.1, 294.8, 294.9).

Table D-1: RAI-MH items used in the analysis

<u>Sociodemographic factors:</u>	<u>Discharge supports and post-discharge outcomes:</u>
Mean age	Prior residential status
% 65 years or older	Economic status
% male	% unemployed
% rural	% making economic tradeoffs
% living in low-income neighbourhoods	Discharge readiness
% homeless	Discharge resources
	Caregiver strain
<u>Diagnostic and related clinical factors:</u>	Revolving door
% of those with concurrent disorders	% rehospitalized for any reason
% of those with dual diagnosis	% rehospitalized for MH/A reason
Provisional DSM-IV diagnostic category	% ED visit within 30-days post-discharge
Positive psychotic symptoms (PSS)	for any reason
Negative symptoms (NSS)	for MH/A reason
Current inpatient status	% OHIP visit within 30-days post-discharge
Indicators of anxiety	for any reason
Psychotropic drug review	for MH/A reason
GAF	
<u>Behavioural and related factors:</u>	
Violence	
Behaviour disturbance	
History of extreme behaviour	
Physical restraints	
Recent criminal activity	
Aggressive behaviour scale (ABS)	
Self-harm	
Addictive behaviours and smoking	
Cognition	
Communication	
Decisional integrity	
Cognitive scale (CPS)	
Activities of daily living (ADL)	
Instrumental activities of daily living (IADL)	
Social function	
Dehydration	
Polydipsia	
Bladder functioning	
Bowel functioning	

Appendix E: “Best Practices” in Transitioning ALC/Long-stay Mental Health and Addictions Clients

The following processes and practices were identified through the project’s literature scan, focus groups and key informant interviews as being key to the successful transitioning of ALC/long-stay mental health and addictions clients. In a nutshell, the focus is on a collaborative, client-centred process that ensures the provision of continuity of care from hospital to community through a high level of engagement from start to finish of all concerned; the patient, the family, hospital and community service providers. Specific service arrangements have been identified as being helpful.

- Initiation of discharge planning in the early stages of admission.
- Use of a collaborative discharge planning process that is tailored to the needs of the individual and involves all relevant community service providers, the client, family and friends working in conjunction with key hospital staff is most effective. The approach should be flexible, client-centred and based on recovery principles.
- Use of discharge checklists help hospital and community staff work together and ensure that everything is covered off in the discharge process.
- The transitional discharge model is a collaborative model that uses a carefully planned client-centred discharge process with ‘in-reach’ and ‘out-reach’ components (Forchuk et al, 1998). Overlap between hospital and community providers helps build new therapeutic relationships while maintaining old ones. The community service ‘gets to know’ the client before discharge.
- Specialized teams in the hospital and the community can be effective transitioning agents such as the Community High Intensity Team (CHIT) at Providence Care Mental Health (PCMH) and the Transition Team in Waterloo. These are multi-disciplinary teams (nursing, occupation therapy and social work) that accept referrals from within the hospital for patients about to be discharged and then follow clients post discharge.
- Successful transitioning strategies within hospital include: the establishment of dedicated ALC beds; education programs for families and patients; implementation of patient flow policies (OACCAC); the presence of staff who can cross boundaries hospital and community boundaries (boundary-spanners); and the active review and monitoring by a senior administrative manager of ALC/long-stay in-patients, ‘ALC Surveillance,’ combined with ongoing efforts to discharge long-stay clients.
- The use of peer support is instrumental in helping to ameliorate client concerns around discharge and in providing a ‘bridge’ between hospital and community. Following discharge, peer support offers valuable assistance around adaptation to the community and development of new support networks.
- Facilitation of community service provider involvement in patient transitioning takes place through: placement of community staff in hospital; their attendance at hospital rounds pre-discharge; spending time with the client in hospital; and taking the client out of hospital gradually until ready for discharge. Outings should include involvement in community activities, establishment of community routines and preferences, and short visits followed by overnight and longer visits to the community residence.
- Following discharge, the provision of various types of hospital back-up to the receiving agency is effective in supporting the placement, e.g., the provision of post-discharge follow-

up/monitoring; providing ongoing access to tertiary care expertise (consultation, education and training); psychiatric back-up; quick readmission policies. These arrangements are most effective when there are formal agreements and/or contracts in place.

- Following discharge the presence of crisis support plans for clients and engage community-based crisis services are helpful in maintaining the community placement.
- The use of trial placement periods/‘guest agreements’ in the residence of 1 to 2 months have proven beneficial.
- The ‘service resolution’ offered by Trellis in Kitchener Waterloo is designed to resolve service barriers that inhibit transitioning of complex mental health clients by promoting service coordination and engaging providers around meeting client short and long-term needs. Service resolution targets adults who are experiencing increased difficulty accessing services and have urgent needs.

Appendix F: Forensic Models

These are two examples of housing programs that could be considered model programs:

Transitional Rehabilitation Housing Programs (TRHP), are designed for persons in forensic hospital units whose Ontario Review Board dispositions allow for community placement. Persons who are referred to TRHP programs require the support that no generic supported housing program could provide. The length of stay is targeted at 12 months. Recovery and psychosocial rehabilitation are the cornerstones of intervention. The programs partner mental health agencies and hospitals to deliver service.

The Toronto program provides for single TRHP units during the Transition period, and a transition to different permanent housing prior to TRHP discharge. The staff ratio in Toronto is 1:5, although in practice more support is involved. Mental Health and Justice Clients are placed primarily through diversion, while Forensic clients are linked to hospital. Nursing support is offered through CAMH.

The Ottawa model (intended for forensic clients), offers congregate to scattered living. Four of the ten spots are in a four bedroom house placed within a residential neighborhood to which persons are referred from the forensic unit and when appropriate move to a TRHP apartment. In this house, there is an office in the basement where group work can be conducted. The remaining six spots are maintained in scattered apartments. When a person is discharged from the TRHP program, they retain their TRHP apartment as permanent accommodation and other apartments are sought for TRHP purposes. Nursing support is also offered within the Ottawa model, however there are nuances in terms of the role of the nurse in the two cities.

Programming is offered in both settings, and the intended/targeted population is clients considered to be low to medium risk. Both sites have 10 spots, for a total of 20 spots across the two cities. Community agencies engage with the client while they are in the hospital to help facilitate the transition. While this transitional housing is intended to be one-year, it seems that more time is actually needed before a client is ready to transfer to generic housing. In both cases, housing is created through partnerships between hospitals and community mental health providers.