Supporting alternate level of care (ALC) patients with a dual diagnosis to transition from hospital to home

Innovative practices across Ontario

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A Companion Report to Supporting Alternate Level of Care (ALC) Patients with a Dual Diagnosis to Transition from Hospital to Home: Practice Guidance

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Introduction

Delayed discharges from hospitals are a significant problem, resulting in poor patient outcomes and delayed access to care. Recently, practice guidance was developed to address the challenge of patients with a developmental disability and a mental illness (i.e., dual diagnosis) who are experiencing prolonged hospital stays throughout Ontario. These patients, designated as Alternate Level of Care (ALC), no longer require hospital care but remain hospitalized due to a lack of appropriate discharge options. This guidance, Supporting alternate level of care (ALC) patients with a dual diagnosis to transition from hospital to home: Practice guidance, identifies a comprehensive set of principles and core components on how to support high-quality transitions from hospital to community settings for ALC patients with a dual diagnosis.

In the development of the Practice Guidance, consultations were conducted with over 100 participants from across Ontario, including service providers from specialized psychiatric hospitals, general health care institutions, community health services, and developmental services. Through these consultations, we learned about many creative and innovative practices being utilized by both hospitals and community organizations to support successful transitions.

This report profiles a selection of these practices to highlight some examples of how to implement the Practice Guidance effectively. This is an initial effort to support knowledge exchange, intended primarily for health and developmental service providers. The practices outlined in this document do not reflect all services and programs that may be available in the province of Ontario. As well, the inclusion of these practices does not constitute evaluation or endorsement by the authors. Ongoing efforts are needed to sustain the sharing of ideas and dissemination of practices that can help implement the Practice Guidance.

The following report is organized around the **ten core transition components** outlined in the Practice Guidance. For each core component, a selection of practices are highlighted that can facilitate its implementation. Each practice is summarized briefly and contact information is provided for those interested in additional information. See the full Practice Guidance for more information on the core components and the elements of care that are needed to support successful transitions.

Component 1: Ongoing information sharing

There is a process in place to support ongoing communication and information sharing between everyone involved in planning and supporting the transition. Communication begins at (or before) admission and continues throughout the patient's hospital stay and the transition period.

Example 1: Standardized process to share key information with hospitals at intake

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

FACTT-DD has a standardized process to share key information with hospitals in the case that one of their clients is hospitalized. Upon notification that a FACTT-DD client is in a hospital emergency department or admitted to an inpatient unit, FACTT–DD staff send the following information:

- the last six months of psychiatrist notes
- Medication Administration Record
- Crisis and Risk Management Plan
- Emergency Services Form

Physician-to physician contact is initiated by FACTT-DD. (Supporting Materials: The Royal FACTT-DD Transition Points Emergency Visits; The Royal FACTT-DD Transition Points Inpatient Admissions).

Example 2: Brief client profile shared with hospitals at intake

MCCSS-funded Developmental Service Organization

The Community Networks of Specialized Care - North Region (CNSC-N) is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

When a client supported by the CNSC-N is hospitalized, CNSC-N provides a one-page profile to the hospital to help staff understand and become acquainted with the client. Where indicated, education is provided to the hospital team regarding legal decision-making, the limitations of voluntary programs/services, as well as how to communicate in a way that the client will understand and be empowered to make decisions.

Example 3: Hospital-supported structured meetings to facilitate communication

Hospital Inpatient Program

The Bayview Program for Dual Diagnosis at Waypoint Centre for Mental Health Care is a patient-centred specialty care program providing a range of services to individuals with a developmental disability and mental health needs.

The hospital program has established a standard process for key meetings at the different stages of inpatient admission to support communication. Patient, family and community providers are invited to the meetings as appropriate.

- **Admission planning meeting**: Gather information to identify treatment goals, create safety support plan, document support needs/activities of daily living (ADLs), sensory needs/preferences and mode of medication administration, describe baseline of when the person is doing well, identify preferences for food/activities, obtain consent for PRN medication and anticipated medication changes (Supporting Materials: Bayview Pre-Admission Meeting Script).
- **First case conference** (2-4 weeks after admission): Discuss observations/assessments and ask for clarification on these, present behaviour and PRN data, discuss incident reports/logs and treatment plan.
- **Case conferences** (typically held monthly but can be more frequent, depending on various factors): Present behaviour and PRN data, discuss any incidents and medication changes to contextualize data; review treatment plan; elicit feedback from family/community partners regarding their own observations during interactions via phone/in-person or video visits.

- **Discharge planning meeting**: The agenda includes review of interdisciplinary recommendations, baseline behaviour data, identification of who is to receive the discharge summary, and coordination for ODSP and OHIP card address change/renewal. If applicable, contact with the outpatient team, role/expectations is also discussed along with referrals for home and community care (e.g. occupational therapy, physiotherapy, injections).

Example 4: Education for hospitals on developmental services

MCCSS-funded Developmental Service Organization

The Community Networks of Specialized Care - Central East Region (CNSC-CE) is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

CNSC-CE maintains very good relationships with hospitals by offering information sessions, providing prompt follow-up when a referral is received through the DSO as well as recommendations on how to access specialized supports in the community. The CNSC-CE has a standard presentation that covers the DSO application process, overview of funding, the role of the CNSC and all their specialized resources. Pamphlets and information for posting in staff and patient areas are also provided. (Supporting Materials: CNSC-Central East Brochure)

Component 2: Comprehensive assessment

Patients receive a developmentally informed comprehensive assessment of their health care and support needs by trained providers, which is used to inform the transition plan and optimize the transition process. Ideally, this assessment is started early upon admission and updated regularly throughout the hospital stay and the transition period.

2.1 Accessing specialized assessments during hospitalization

Key to completing this component is access to trained clinicians who are able to conduct the necessary specialized assessments. In some cases inpatient units may have access to these trained providers within the unit (see example 1), they may have access through consultation units within the hospital (see example 2), patients may already be connected to outpatient programs who can provide assessments (see example 3), or assessments may be accessed through developmental service organizations (see example 4).

Example 1: Specialized assessments within the inpatient unit

Hospital Inpatient Program

Providence Care Hospital provides rehabilitation, complex medical care, palliative care and mental health programs. Approximately one-third of admissions are individuals with a dual diagnosis.

This unit provides assessment, stabilization, and transition planning supported by a team that includes developmental service workers and behaviour technology, in addition to psychiatry, registered nursing, registered practical nursing, occupational therapy, physiotherapy, spiritual health, registered dietician, speech and language therapy, social work, and recreation. Limited access to psychology services is available to support more complete assessments and testing should that be required.

Example 2: Specialized assessments by hospital dual diagnosis consultation service

Hospital Consultation Service

The Royal Dual Diagnosis Consultation Team in the Community Mental Health Program at The Royal Ottawa Hospital provides specialized assessment and consultation to the community, as well as inpatient units within the Royal and general hospitals within the Ontario Health Eastern Region.

The Royal Dual Diagnosis Consultation Team assists hospital inpatient services in the region with treatment and transition planning by providing specialized assessment and consultation to inpatient adults (18 years of age and older) admitted to the Royal and general hospitals within the Eastern Ontario Health Region. Referrals are for individuals who have a documented intellectual disability, mental health concerns and may experience significant behavioural challenges, increased risk to self and others, risk of losing housing or programming, and lack social and community resources and connections. The multidisciplinary team includes psychology, psychiatry, nursing and behaviour therapy. (Supporting Materials: The Royal Dual Diagnosis Consultation Team Information Sheet)

Example 3: Specialized assessments by hospital outpatient program

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

FACTT-DD provides specialized assessment and consultation to inpatient units for their registered clients who are admitted to hospital. Services may include an occupational therapist, behavioural therapist, nursing, psychology or psychiatry specialist providing recommendations to inform inpatient treatment plans such as ADL skills training, positive behavioural approaches, and medication, as well as transition planning. (Supporting Materials: The Royal FACTT-DD Information Sheet).

Example 4: Specialized assessments by community-based teams

MCCSS-funded Developmental Service Organization

The Community Networks of Specialized Care - Central East Region (CNSC-CE) is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

The CNSC-CE provides access to specialized assessments and consultations, including the following:

- **Mobile Resource Team (MRT)** - made up of a multidisciplinary team of professionals that reviews profiles of complex persons and provides recommendations for accessing specialized resources and treatment. The MRT can be accessed through the DSO in the Central East Region by making a referral for Service Solutions to determine long-term supports for persons with complex needs.
- **Mobile Outreach Team (MOT)** - conducts observations to develop comprehensive recommendations using the biopsychosocial approach. The MOT's assessment identifies the appropriate supports to stabilize the person in their current environment.

Funding for specialized assessments for persons with complex needs is accessed through the CNSC-CE specialized transition coordinator.

2.2 Utilizing appropriate assessment tools

Having the right assessment tools is crucial for effectively evaluating dual diagnosis patients upon admission to hospital to better understand the patient and their needs. Assessment tools can aid in ensuring appropriate treatment, connecting to community-based resources, and supporting successful transition planning.

Example 1: The Recovery Plan of Care electronic comprehensive assessment

Hospital

Waypoint Centre for Mental Health Care is a specialty mental health hospital located in Penetanguishene.

The Recovery Plan of Care is an electronic comprehensive assessment tool used by all inpatient programs at Waypoint Centre for Mental Health Care, as well as at Ontario Shores Centre for Mental Health and The Royal Ottawa Hospital. Though not designed specifically for people with dual diagnosis, it provides a framework for goal setting and transition planning during hospitalization that is relevant to this population. It consists of five main sections:

1. Recovery - identifies the patient's recovery goal, which is recorded in the patient's own voice verbatim.
2. Physical Well-Being - contains all information related to the patient's physical health needs and interventions, and related goal(s).
3. Clinical Assessment Protocols (CAPs) - includes 19 key health- and psychosocial-focused themes. At Waypoint Centre, clinicians engage with the patient and/or substitute decision-maker (SDM) to collaboratively prioritize 3-5 CAPs and related goals to focus on at a time. Some priority areas within the CAPs may be triggered by various risk assessments and/or the Resident Assessment Instrument – Mental Health (RAI-MH).
4. Conference - documents all clinical and family meetings.
5. Support Systems for Discharge - consolidates all transition and discharge planning documentation.

2.3 Process to support rapid connection with DSO

A key part of the assessment process is connecting with the DSO as soon as possible after admission to confirm eligibility, whether the patient is currently receiving any MCCSS-funded developmental services, and initiate referrals to any necessary services. The DSO may also have information regarding current and historical needs including prior assessments (conducted when the individual was in school or through the DSO).

Example 1: Proactive outreach to build relationships and communicate effectively with local hospitals

Developmental Services Ontario

Developmental Services Ontario, Hamilton-Niagara Region (DSO HNR) is one of nine regional offices of the DSO, the access point for all adult MCCSS-funded developmental services in Ontario.

DSO HNR has taken proactive steps to meet with local hospitals to build relationships, enhance awareness of the DSO, and provide guidance on how to connect if they have a patient suspected or confirmed to have a developmental disability. DSO HNR has established a written protocol with one hospital to share information and provide regular monthly touchpoints with key personnel (e.g., discharge nurse, social work supervisor) regarding patients seen in the emergency department, admitted to hospital, and/or designated as ALC. Efforts are underway to extend this relationship to all hospital systems in the region. DSO HNR also offers educational presentations to hospitals regarding the role of the DSO, and relevant services available (e.g., Passport funding). (Supporting Materials: DSO HNR – St. Joseph's Hospital Protocol)

Component 3: Patient and family involvement in transition planning

A person-centred, family-centred and culturally appropriate approach is used throughout the transition process. The person transitioning from hospital to community, together with those that support and know them best, are involved in planning the transition and developing a written transition plan. The patient and family are also provided support to address any anxieties, concerns or trauma related to the hospital stay and/or transition process.

Example 1: Expanded hospital privileges for patients and family members to support daily living skills and well-being

Hospital

The mental health program at Windsor Regional Hospital provides emergency psychiatric assessments through its Mental Health Assessment Unit, and offers admission to either a 65-bed acute mental health program, or 8-bed Psychiatric Intensive Care Unit.

Windsor Regional Hospital has a practice of supporting inpatients with dual diagnosis by offering them extended privileges compared to the general patient population. For example, patients with a dual diagnosis are able to participate in day programs outside of the hospital to improve reintegration into the community. Family members are encouraged and supported to participate in providing patients' basic ADLs while in hospital and may visit and stay outside usual visiting hours with physician and administration approval.

Component 4: Patient, family and community provider education, training, and support

Before transitioning from hospital, the patient, their family, and the health care and developmental service providers who will be supporting them in the community are provided the information and training they need to manage the patient's physical and mental health care needs. This includes spending time with the clinical team and the patient in hospital to observe and learn these skills.

Example 1: Education for forensic dual diagnosis inpatients and outpatients, hospital staff, and family caregivers

Hospital Inpatient/Outpatient Program

CAMH Forensic Dual Diagnosis Specialty Services (FDDSS) provides multidisciplinary services to adults with suspected or confirmed intellectual and developmental disabilities involved with the Ontario Review Board (ORB) or the justice system, or at risk of justice involvement. These services include assessment, consultation, case management, transition planning, and system coordination.

The FDDSS provides accessible education and training sessions for forensic dual diagnosis inpatient and community clients on topics such as sexuality (anatomy, sexual hygiene, safer sex), boundaries, and housing. Specialized sessions are also available for families. (Supporting Materials: CAMH FDDSS Sample Client Training Modules)

Additionally, focused training sessions are offered to inpatient and community staff supporting forensic clients, covering a range of topics including behavioural competencies, developmental service solutions/systems navigation, suicide Intervention skills, clinical topics such as Clozapine administration, harm reduction in people with intellectual and developmental disabilities, and sexuality training. The service organizes an annual provincial conference for providers and families to facilitate collaboration and information exchange between developmental services and forensic mental health systems.

Example 2: Outpatient education for dual diagnosis inpatients, hospital staff and family caregivers

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

The FACTT-DD Program offers a range of dual diagnosis training options for its clients as well as the broader community to address specific needs and requests, including staff training for implementing individual transition and positive behaviour support plans. Additionally, general education sessions are available virtually through The Royal Family Group training program.

Component 5: Transition and Community Support Plan

A written Transition and Community Support Plan is developed that identifies the most appropriate housing, developmental services and health care supports necessary for the person to live successfully in the community and outlines a graduated transition process. Transition planning begins when the person is admitted to hospital and the plan is updated regularly throughout their stay and the transition period.

Note: There are many different transition plan templates in use across the province. Below are a few examples that reflect some of the elements of a comprehensive Transition and Community Support Plan articulated in the Practice Guidance.

Example 1: Comprehensive Service Profile completed with information received from the patient, family, and other providers

MCCSS-funded Developmental Service Organization

The Community Networks of Specialized Care - Eastern Region (CNSC-E) is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

The CNSC-E complex support coordinator initiates an individualized transition planning process by completing a Service Profile template with information received from the individual, family, and other providers. (Supporting Materials: Individual Service Profile).

The completed profile is further informed by the Needs Assessment/ Transition Plan Guide, a tool adapted with permission from Tamir, a developmental service agency in the region. (Supporting Materials: Tamir Transition Plan Guide and Template) The guiding questions cover ten general domains of an individual's life and help to obtain a broader understanding of needs, interests, preferences, and the associated services and/or types of support required.

The Complex Support Plan template (Community Networks of Specialized Care Ontario), is then used to track action items and progress with all stakeholders as per assigned responsibilities. (Supporting Materials: CNSCO Complex Support Plan)

Example 2: Crisis plan completed in consultation with behaviour consultant, the patient, family, and other providers

MCCSS-funded Developmental Service Organization

The Southern Network of Specialized Care/Bethesda is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

The Southern Network of Specialized Care/Bethesda uses a series of crisis plan templates to support transition planning, avert re-hospitalization post-discharge or frequent hospital visits, and guide families on accessing community supports or emergency services as needed. Crisis plans are developed in consultation with a behaviour consultant, along with the individual, family, community providers, and emergency and hospital services as indicated. The Southern Network's complex support coordinator or the behaviour consultant disseminate completed plans to relevant parties for implementation.

- **My Safety Plan** is used for individuals who can develop and follow their own plan to help keep themselves safe. It is written in the first person and allows the individual to list what strategies help them when they are not feeling safe (i.e., whom they can talk to, where they can go, etc.). This would be a personal plan for that person and not typically shared with others in the community. (Supporting Materials: My Safety Plan).
- **Individual Crisis Plan** is a more formal document designed for community program staff. It is also shared with community partners, such as emergency services, mobile crisis, hospital, etc. It provides a snapshot of information regarding the person, what may be helpful or not helpful in a crisis, the steps at each level along the de-escalation continuum, as well as the support system involved. (Supporting Materials: Individual Crisis Plan).
- **One Page Crisis Plan** is used alongside the Individual Crisis Plan and is a condensed and more simplified format. This is beneficial for anyone supporting the individual who may have difficulty discerning the important information from the Individual Crisis Plan. For example, a family member may use this as a quick reference guide. (Supporting Materials: One Page Crisis Plan).

- **Family Safety Plan** is designed for families of an individual who may be in crisis. As the individual is living with family, the plan focuses on strategies reflective of the home environment. While the plan includes de-escalation techniques, its focus is on prioritizing safety in potentially unsafe situations, such as reaching out to another family member or neighbour during emergencies. (Supporting Materials: Family Safety Plan).

Component 6: Graduated, overlapping and coordinated transition

An identified lead from the hospital and an identified lead from the community work closely with the patient, their family, their hospital team and their community health and developmental service providers to support a graduated, coordinated transition which includes a period of overlapping care.

6.1 Shared role of transition coordinators

Clearly identified leads from both hospital and community settings are needed to share responsibility and work together to plan, support and coordinate hospital-to-community transitions. This ensures effective coordination while also considering individual capacity and workload. Hospitals and community providers have adopted different approaches and roles, depending on patient, program and system needs. In the examples highlighted, one mental health hospital has a manager responsible for developing system partnerships for ALC clients (see example 1); a developmental service agency and outpatient mental health program have identified staff to support transitions for patients who will be receiving care from their program post-discharge (see examples 2 and 3); and three developmental service agencies provide regional or provincial transition coordination services (see examples 4, 5, and 6).

Example 1: Hospital-based dedicated transition manager responsible for identifying ALC patients and partnering with community organizations

Hospital Inpatient Program

Centre for Addiction and Mental Health (CAMH) is a specialized mental health and addiction teaching hospital.

CAMH has a dedicated transition manager responsible for identifying ALC clients and developing unique partnerships and housing models with community stakeholders to ensure safe and successful transitions. The manager also supports CAMH inpatient programs and outpatient teams with matching clients to the right housing and outpatient supports, focusing on transition and community support planning.

Example 2: Developmental service-based dedicated transitions coordinator

MCCSS-funded Developmental Service Organization

Kerry's Place Autism Services provides supports and services across Ontario to children, youth and adults with Autism, and their families.

Kerry's Place has a dedicated manager of service connections responsible for leading the transition process for all new residential admission candidates. This includes coordinating with the individual and their family/support circle, hospital and/or community services leads, funders, as well as the internal Kerry's Place team. With this role, the organization has established consistent procedures with templates and checklists to organize and track the transition process as well as measurable outcome indicators. (Supporting Materials: Kerry's Place Manager of Service Connections)

Example 3: Hospital outpatient and inpatient staff co-leading the transition process

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

A FACTT-DD prime worker connects with the lead inpatient social worker to coordinate and plan transition and discharge for FACTT-DD registered clients who are admitted to hospital. During hospitalization, the inpatient unit is the lead clinical team and FACTT-DD provides consultation, support, and training. At discharge, FACTT-DD becomes the lead team and receives consultation from the inpatient team regarding discharge supports as needed. The agenda for transition planning meetings prior to discharge generally includes: hospital update on client status on the unit; community partners update; family update; discharge planning; and roles and responsibilities. (Supporting Materials: The Royal FACTT-DD Transition Points Emergency Visits; The Royal FACTT-DD Transition Points Inpatient Admissions)

Example 4: Developmental service-based staff support transition planning in region

MCCSS-funded D*evelopmental Service Organization*

Sunbeam Developmental Resource Centre offers a range of professional and support services to individuals with a developmental disability and/or Autism and their caregivers, as well as assists with connecting to services and supports in South-West and Central Ontario.

A service coordinator and/or the Service Solutions facilitator from Sunbeam Developmental Resource Centre (SDRC) partners with the hospital social worker to lead the development and implementation of Transition and Community Support Plans, coordinate access to funding, and/or clinical resources available in the community or at Sunbeam (e.g., behaviour, social work and speech-language pathologist consultation). The team supports hospital staff with programming and post-discharge planning, and provides consultation and support to residential providers. If the individual requires mental health support and follow-up post-discharge, CMHA Service Resolution facilitators facilitate access to mental health resources to support residential placement within the developmental sector.

Example 5: Dedicated developmental service-based case manager to coordinate the transition process with hospitals, funders, and receiving providers

MCCSS-funded D*evelopmental Service Organization*

Individualized Planning Resource Development and Oversight (IPRDO) Program, Community Living Fort Erie is a provincial program providing planning and support resources when Transfer Payment Agencies (TPAs) lack the current capacity for individuals who have been prioritized for planning. Temporary residential placement may involve Outside Paid Resources (OPRs) funded on a per diem basis.

The IPRDO case manager negotiates and coordinates planning and implementation of the transition process with hospitals, funders, and receiving providers for individuals eligible for transitional housing through the OPR program (funded on a per diem basis).

The case manager role includes facilitating transition planning meetings, ensuring clear timeframes to complete assigned tasks and reporting results in each meeting. The case manager works with the individual OPRs to establish the necessary clinical and environmental supports, preparing the funding plan (Multi-Year Supported Living Plan-MYSLP) for approval by MCCSS, and ensuring that necessary procedures are in place at discharge (e.g., notification of ODSP, medication transfers and communication with the chosen pharmacy, and occupational/physical therapy transition from hospital to community-based care).

The case manager works closely with hospital social workers to manage and coordinate all necessary hospital supports such as occupational/physical therapy services. The hospital social worker will assist community behaviour services to gain access to the patient to develop behaviour support plans, and work with the hospital-based team to create PRN, medical and safety protocols aligned with requirements of the MCCSS Quality Assurance Measures (QAM). Upon discharge to the OPR, the case manager continues to support planning and transition until the individual secures a permanent placement in the adult developmental service sector, while also monitoring OPR compliance with QAM.

Example 6: CNSC transition coordinator and hospital staff work together

MCCSS-funded Developmental Service Organization

The Southern Network of Specialized Care/Bethesda is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

Once the Southern Network of Specialized Care is engaged, either because the patient is an existing client or the hospital has contacted them, the coordinator will initiate a conversation with inpatient social workers regarding their respective roles supporting the transition and discharge planning process. This is often based on the current capacity of each person's workload while also being respectful of roles and accountabilities. During the transition planning phase, the complex support coordinator is generally responsible for connecting the individual to developmental services

such as clinical services (e.g., behaviour consultation, speech and language therapy, counselling).

6.2 Hospital and community collaboration to support graduated transitions and discharge readiness

Transitions for this population should be graduated and allow for a period of overlapping care from the hospital and community teams. The aim is to facilitate smooth transitions for patients between hospital and community settings, ensuring continuity of care and support while preventing relapse or deterioration in the patient's condition.

Example 1: Community agency-hospital partnership to fund developmental services on inpatient units

MCCSS-funded Developmental Service Organization

Options Northwest is a MCCSS-funded developmental service agency serving Thunder Bay and its surrounding district in Northwestern Ontario.

Options Northwest partners with Thunder Bay Regional Health Sciences Centre (TBRHSC) to enhance the discharge readiness of patients identified as having a developmental disability who are considered ALC. TBRHSC funds Options Northwest for 40 hours per week to deliver a range of behavioural services and supports to patients on the Forensic Unit, including individuals with a dual diagnosis, as well as consultation to other adult mental health patients as needed. The behavioural workers help with conducting functional assessments, engagement in therapeutic activities at the hospital or in the community, and developing individualized care plans. Following transition, patients may be supported on an outpatient basis as long as needed. Additionally, in collaboration with hospital staff, there is ongoing assessment of staff educational needs and development of educational activities.

Example 2: Mobile services to develop individualized behavioural support plans and build community capacity

Hospital Outpatient Program

Adult Neurodevelopmental Services - Alternate Level of Care Program is a partnership between CAMH and Lumenus Community Services.

The CAMH behaviour therapist offers mobile services, conducting functional assessments and creating individualized behavioural support plans in collaboration with clients, family, staff and service providers. Additional specialized consultation is available from psychiatry, occupational therapy, nursing, psychology, and social work from the Adult Neurodevelopmental Services. Griffin Community Support Network (GCSN) provides coordination and short-term flexible staff as needed, contingent upon clinical need and available funding. Eligible clients have a dual diagnosis, are designated as ALC in hospital inpatient units or MCCSS community treatment beds, and exhibit physical aggression, environmental destruction or disruptive behaviour and various social skill deficits. Maximum service duration is two years. The goal of this partnership is to collaborate and build capacity with community care providers to facilitate successful transitions and prevent emergency room visits or re-admissions. (Supporting Materials: CAMH - Lumenus ALC Program Postcard).

Example 3: Behavioural consultation and training to hospital inpatient units

MCCSS-funded Developmental Service Organization

The Community Networks of Specialized Care - Central East Region (CNSC-CE) is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

Behavioural consultation and training for hospital inpatient units to support implementation of transition plans can be provided by community-based behaviour agencies. Depending on the individual's home location, these services are provided by the Centre for Behaviour Health Sciences at Mackenzie Health, Lake Ridge Community Support Services or Canopy Support Services for the Central East region. These clinicians can also attend

the pre-discharge transition planning meetings as well as provide consultation and training to community home providers. Referrals to access these behavioural consultations are made through the Developmental Services Ontario – Central East Region. When there is a waitlist to access these clinical services, a referral can be made to the CNSC-CE for Transitional Behaviour Consultation Services provided by Lake Ridge Community Support Services until the community-based clinical agency is able to provide the ongoing clinical support.

Example 4: Alignment of pre-discharge hospital programming with post-discharge community programming

MCCSS-funded Developmental Service Organization

Vita Community Living Services offers integrated multidisciplinary supported-living and clinical services to support the needs of adults with developmental disabilities and dual diagnosis with more complex behavioural and/or forensic histories.

For patients moving to Vita, throughout the transition and discharge planning process Vita program supervisors coordinate with hospital social workers, the inpatient care team, and Vita behaviour analysts to engage with other inpatient staff/behaviour analysts or community-based clinicians involved with the patient. This collaboration aims to identify and facilitate the implementation of pre-discharge programming to align with the community post-discharge programming. Vita's consulting psychiatrist may become involved if the individual has been discharged from the care of a previous community psychiatrist.

6.3 Hospital policies to support graduated transitions and discharge readiness

Hospital policies and practices should support gradual transitions from hospital to community settings. This approach aims to ensure discharge readiness of ALC patients and prevent relapse or deterioration in their condition.

Example 1: Hospital policies to support overlapping care

Hospital

Windsor Regional Hospital provides comprehensive health care services to patients in the Windsor and Essex regions, as well as quaternary care to a broader population.

Windsor Regional Hospital encourages community staff to participate in providing basic activities of daily living during hospitalization to support transition planning and skill building to prevent patient decompensation during this period. These visits can also occur outside the usual visiting hours with physician and administration approval. Clients may also visit or spend an overnight in the community home prior to discharge to support smooth transitions.

Example 2: Assignment of developmental service workers on inpatient units

Hospital

Providence Care Hospital provides rehabilitation, complex medical care, palliative care and mental health programs. Approximately one-third of admissions are individuals with a dual diagnosis.

Providence Care Hospital employs developmental service workers (DSW) on their general inpatient mental health unit, where they play a key role supporting patients with a dual diagnosis. They focus on supporting patients in daily life skills, fostering skill development, and facilitating engagement in activities tailored to individual needs and abilities. DSWs provide compassion and consistency while assisting in the implementation of behavioural support plans, often serving as role models to individuals and coworkers for effective methods of communication and support. In collaboration with the inpatient social worker, they also support individuals during the transition process by facilitating day visits to community home environments.

Example 3: Temporary leaves of absence from hospital grounds

Hospital Inpatient Program

The Bayview Program for Dual Diagnosis at Waypoint Centre for Mental Health Care is a patient-centred specialty care program providing a range of services to individuals with a developmental disability and mental health needs.

The Bayview Program for Dual Diagnosis offers a graduated or stepwise transition approach, starting with initial visits by family or community providers that occur in the hospital setting with clinicians nearby. Once the patient feels comfortable, visits progress to hospital grounds and then off-site. If appropriate, a trial Leave of Absence (LOA) for up to 72 hours is offered, with extensions granted while the person/patient is on leave for reasons such as extreme weather. LOAs can be a useful tool for evaluating response to treatment. Virtual observations through platforms such as Zoom can be used as well. Multiple LOAs per week are permitted, so long as an overnight hospital stay separates them. The focus is on maintaining positive relationships with community partners, including family and/or service providers.

Component 7: Medication review and support

Patients have medication reviews at admission, before discharge and once they are in the community, which include information regarding medication reconciliation, adherence and optimization. There is a plan in place for accessing medications in the community, ongoing medication monitoring and supporting medication administration.

Example 1: Standard process for medication review and support during hospitalization

Hospital Inpatient Program

The Bayview Program for Dual Diagnosis at Waypoint Centre for Mental Health Care is a patient-centred specialty care program providing a range of services to individuals with a developmental disability and mental health needs.

The Bayview Program discharge planning meetings include a standard process to review diagnosis and individual medications, baseline PRN frequency, confirmation of community pharmacy for medication reconciliation and responsible health care provider for prescription refills.

Example 2: Post-discharge medication review and support by hospital outpatient program

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

Upon discharge from hospital, the FACTT-DD psychiatrist and nurse are responsible for medication reconciliation as well as ensuring that the community pharmacist receives all the necessary information. Additionally, the FACTT-DD psychiatrist meets with all patients within two weeks of discharge to review and adjust medications as indicated as well as to create the necessary orders to be processed by the nurse. The patient's primary care provider or other specialists receive copies of all psychiatric consults.

The prime worker is responsible for ensuring the FACTT-DD team is up-to-date regarding any physical health issues or medications as per the community primary care provider.

Component 8: Coordinated follow-up medical and clinical care

Appropriate health care is provided throughout the transition period and, prior to discharge, all necessary health care providers are identified and prepared to provide follow-up care in the community. All patients require a primary care provider and some may also require other providers such as psychiatrists, psychologists, behaviour therapists, social workers, nurses, occupational therapists and speech-language pathologists, as well as case-coordination. For people with complex needs, a multidisciplinary team-based approach is required.

8.1 Team-based clinical care models

In Ontario, there are diverse multidisciplinary team models for supporting individuals with a dual diagnosis, including outpatient services within hospitals, community health care providers, and developmental service agencies, as well as partnerships across multiple organizations. Examples of these team models are described below, categorized based on primary funding sources, with some reflecting joint funding arrangements resulting from creative partnerships at the local/regional/provincial level. The integration of these models within a local region ensures clients registered to these teams can receive a continuum of services through periods of hospitalization.

8.1.1 Ministry of Children, Community and Social Services (MCCSS) funded

Example 1: Integrated clinical support model for transition and community reintegration

MCCSS-funded Developmental Service Organization

Vita Community Living Services offers integrated multidisciplinary supported-living and clinical services to support the needs of adults with developmental disabilities and dual diagnosis with more complex behavioural and/or forensic histories.

Vita offers an integrated clinical support model to individuals participating in their supported living treatment programs. The clinical team includes behaviour analysts, consulting psychiatrist, and a consulting psychologist. They work closely with hospital clinicians during the transition planning and discharge phases. Upon discharge from hospital, the same team, along with

housing staff, provides individualized support regarding programming, management of risk and safety, medication monitoring (for those members who do not have a community psychiatrist), in addition to access to art therapy, counselling and pro-social supports.

The clinical team provides consultation and a period of overlapping service when individuals are ready to transition within Vita or to another less intensive housing provider in the community. Individuals participating in this program have gone on to successfully re-integrate into the community, transitioning back to their family homes or other housing support programs to live permanently, as well as attending volunteer placements, drop-in programs and paid employment.

Example 2: Comprehensive multidisciplinary clinical and coordination services

MCCSS-funded Developmental Service Organization

Bethesda Services is a multi-service organization that provides a range of clinical, intensive treatment, supported living and day services for adults and is the lead agency for the Southern Network of Specialized Care.

As one of the lead agencies for the Southern Network of Specialized Care, a range of multidisciplinary team-based services are available within Bethesda and/or from other providers in the region for assessment, treatment, consultation, education, training, as well as post-discharge community follow-up. Clinical services may include speech and language pathology, psychometry, social work, behaviour consultation, and occupational therapy. For example, the Community Response Program is an intensive treatment program with comprehensive person-centred support for individuals with more complex needs. Services include clinical team support, outreach, assessment bed (Vineland, ON) community treatment, intensive treatment (Vineland, ON), and community training.

Example 3: Bringing together multidisciplinary clinical services to meet individual needs

MCCSS-funded Developmental Service Organization

Individualized Planning Resource Development and Oversight (IPRDO) Program, Community Living Fort Erie is a provincial program providing planning and support resources when Transfer Payment Agencies (TPAs) lack the current capacity for individuals who have been prioritized for planning. Temporary residential placement may involve Outside Paid Resources (OPRs) funded on a per diem basis.

Individuals referred to IPRDO for transition planning from hospitals often experience very long admissions because of more complex and severe medical, behavioural and/or psychiatric difficulties including self-injury, physical and environmental aggression, or sexualized behaviour.

Some of the per diem-funded housing supports receiving these clients for temporary placement have an established multidisciplinary clinical team attached to the service. They are able to accept clients with higher complexities and provide pre-placement clinical services (e.g., seeing the client while in hospital to complete data collection, developing behaviour support plans, and providing staff training). If the per diem provider does not have these resources or there are service gaps, the IPRDO will bring together multidisciplinary clinical services to meet these needs. This may include behaviour therapy assessment and consultation during hospitalization as well as follow-up in the community, occupational therapy, speech and language therapy, nursing (for such needs as wound care or insulin training), and non-OHIP funded services for psychiatric consultation to the community team and program. Some of these services may need to be purchased when the location is more remote. In some cases, as part of the transition plan, IPRDO will also negotiate time limited hospital follow-up services such as post-discharge support for up to 90 days by a social worker, or medication follow-up by a hospital psychiatrist until community-based care can be established.

8.1.2 Ministry of Health (MOH) funded

Example 1: Multidisciplinary transition and post-discharge services for forensic patients

Hospital Inpatient/Outpatient Programs

Centre for Addiction and Mental Health (CAMH), Forensic Dual Diagnosis Specialty Services (FDDSS) provides multidisciplinary services to adults with suspected or confirmed intellectual and developmental disabilities involved with the Ontario Review Board (ORB) or the justice system, or at risk of justice involvement. These services include assessment, consultation, case management, transition planning, and system coordination.

FDDSS receives referrals from CAMH inpatient or outpatient forensic programs when the transition process and clinical needs for individuals with a dual diagnosis are more complex. Individuals eligible for FDDSS have a suspected or confirmed intellectual and developmental disability, are at least 18 years of age and are the subject of a disposition under the ORB and/or, have current or pending criminal charges/ recent justice involvement and/or are registered with the Forensic Early Intervention Service. The multidisciplinary team includes a nurse, behaviour therapist, social worker, and psychologist. Transitional and post-discharge follow-up services may include assessment, consultation, case management, transition planning, and system coordination.

Example 2: Post-discharge follow-up services

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

Prior to hospital discharge FACTT-DD identifies follow-up medical and clinical services that will be provided at discharge as well as the assigned multidisciplinary team members. The team includes psychology, psychiatry, nursing, occupational therapy, behavioural therapy, social work, mental health and developmental service workers. During the first two weeks post-

discharge, FACTT-DD offers more intensive support including a meeting with the FACTT-DD psychiatrist, daily team review meetings, and on-site visits as required. The intensity of service is adjusted over time, as needs decrease or increase. FACTT-DD is also able to increase or decrease the intensity of services as individual or caregiver needs change. (Supporting Materials: The Royal FACTT-DD Information Sheet)

8.1.3 Jointly funded by MCCSS and MOH

Example 1: Post-discharge follow-up services

Hospital Outpatient Program

The Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) at The Royal Ottawa Hospital is an outpatient program in the Community Mental Health Program that provides intensive community support for individuals with a dual diagnosis.

Post-discharge follow-up services are available in Pembroke and Cornwall through additional MCCSS funding to the FACTT-DD services. To address local resource gaps, MCCSS funds a full-time nurse and behaviour therapist located in FACTT-DD satellite offices in each location. The FACTT-DD multidisciplinary teams from Ottawa and Brockville provide additional psychiatry, psychology, occupational therapy, mental health and developmental service workers, and social work consultation and support as indicated. (Supporting Materials: The Royal FACTT-DD Information Sheet).

Example 2: Developmental services collaborative partnership with family health teams

MCCSS-funded Developmental Service Organization

Reena is a faith-based community agency supporting individuals with developmental disabilities and their families from all denominations, offering a variety of services including residential support, community participation supports, respite and outreach programs, and advocacy.

Reena has established collaborative relationships with Family Health Teams (FHTs) as a way of building capacity within primary care for individuals with dual diagnosis and more complex needs. The FHT model is one that offers a multidisciplinary team approach (including family physicians, nurse practitioners, registered nurses, social workers, dietitians etc.), ideal for addressing complex needs where a variety of practitioners working together is required. Nurse practitioners have the capacity to spend additional time with the individual and their developmental service staff as needed to ask questions and sort out complex issues such as setting up ways for staff to track data to assist with monitoring new or ongoing health issues.

In connecting and collaborating with FHTs, Reena has been able to jointly develop and streamline administrative processes that can reduce barriers to care. This includes:

- Using the FHTs' EMR to produce a quick report after a visit so additional documentation is not needed (while also meeting the documentation requirements for developmental service agencies and regulations by MCCSS).
- Providing the FHT with key contacts within the agency so that issues or concerns can be resolved quickly.
- Ensuring that developmental service staff come prepared to appointments, with any necessary data and information.
- Augmenting FHT resources by providing specialized clinicians available to Reena to attend a case conference or provide additional assessment, such as occupational or behaviour therapy.

Recognizing that primary and other medical care for individuals with developmental disabilities and/or a dual diagnosis has always been a challenge, Reena continues to engage in system level advocacy through participation with the Western York Region Ontario Health Team to further these partnerships.

8.2 Health/mental health care follow-up

At discharge, some individuals may need specialized health care follow-up including psychiatry, other specialist physicians, psychology, behaviour therapy, social work, nursing, occupational therapy, or speech-language pathology, in addition to developmental services. These services are coordinated by a community coordinator, case manager, or housing provider to ensure comprehensive support for an individual.

Example 1: Coordination between CNSC health care facilitators and home care agencies

MCCSS-funded Developmental Service Organization

The Community Networks of Specialized Care - Central East Region (CNSC-CE) is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

The CNSC-CE health care facilitator collaborates with identified Home and Community Care case managers who specialize in referrals for individuals with developmental disabilities in the Central Region Home and Community Care Support Services (HCCSS). Additionally a Home Care contracting agency in York region employs nurses and PSWs that have specialized backgrounds in working with individuals with intellectual and developmental disabilities to provide in-home services upon discharge from hospital.

Example 2: Hospital post-discharge follow-up

Hospital Outpatient Program

Windsor Regional Hospital provides comprehensive health care services to patients in the Windsor and Essex regions, as well as quaternary care to a broader population.

Windsor Regional Hospital works with the housing agency to support post-discharge follow-up from the hospital through the hospital outpatient mental health clinic. The primary care provider is able to call the clinic for any questions they may have regarding an individual. This helps the primary care provider and housing provider feel more comfortable accepting the patient and not abandoned. This is available for 30-90 days post-discharge.

Example 3: Hospital short-term post-discharge consultation

Hospital Inpatient Program

Ontario Shores Centre for Mental Health Sciences, Dual Diagnosis Program provides a range of specialized assessment and treatment services to those living with complex and serious mental illness. The Dual Diagnosis Program is a specialized inpatient treatment program for individuals with a dual diagnosis.

Ontario Shores' Dual Diagnosis Program provides some short-term post-discharge consultation for specific long stay individuals for whom transition and discharge may be more difficult. Psychiatric consultation may be provided to the receiving most responsible physician as well as community teams. The dual diagnosis outreach nurse may also be involved to support housing providers, primarily regarding behavioural management approaches.

Example 4: Pre- and post-discharge behavioural support

MCCSS-funded Developmental Service Organization

Community Networks of Specialized Care - Toronto Region is one of eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region.

Prior to discharge, a behaviour facilitator with the CNSC-Toronto team may be engaged to support transitions, particularly when a safety plan is required, to review an existing behavioural plan, and when behaviours pose a barrier to accessing services. Responsibilities include:

- Creating safety plans and providing training to families, care providers and community partners to enable improved safety. (Supporting Materials: Safety Plan Template CNSC Toronto)
- Providing support in implementation of existing behavioural plans in new environments (e.g., hospitals, new housing, shelters).
- Creating changes in existing behavioural plans to adapt to new situations.

Component 9: Appropriate and timely housing and community support

Housing and community services are identified that meet individual needs and preferences, promote a sense of belonging and support them to feel safe and comfortable. Considerations include proximity to family, services and community; the physical environment; other residents; cultural appropriateness; and staff supports.

9.1 Housing models

A home in the community needs to be the right fit for the individual, ensuring it offers the necessary support and programs to encourage community engagement and daily activities. Integrative housing models, which bring together mental health and developmental services, may benefit some individuals.

Example 1: Mental health housing for individuals with complex mental health and behavioural needs

Community Agency

Percy Place is a program at the Canadian Mental Health Association, North Bay and District, a Mental Health, Addictions and Peer Support agency that specializes in support services to people with a serious mental illness.

Percy Place is designed to accommodate adults who have a serious and persistent mental illness in conjunction with other medical and/or behavioural complexities, transitioning from hospital setting or internal transfers within the organization. The program has been successful for individuals with dual diagnosis who have less complex needs. The focus of Percy Place is a recovery-based approach with affordable housing, meals, assistance with activities of daily living, and 24-hour onsite support provided by a registered practical nurse (RPN), personal support worker (PSW), peer support worker, and nurse case manager. Partnerships with North Bay Regional Health Centre, local pharmacies, as well as physicians provide additional support. The purpose is to improve and stabilize an individual's physical and mental health, independence, participation and integration in the community, and quality of life with the hope of avoiding and/or decreasing hospitalization. (Supporting Materials: Percy Place)

Example 2: Transitional step-down housing for forensic inpatients

Hospital Outpatient Program

CAMH Forensic Dual Diagnosis Specialty Services (FDDSS) provides multidisciplinary services to adults with suspected or confirmed intellectual and developmental disabilities involved with the Ontario Review Board (ORB) or the justice system, or at risk of justice involvement. These services include assessment, consultation, case management, transition planning, and system coordination.

The Dual Diagnosis Transitional Housing Program (DD-TRHP) is a transitional step-down housing program for individuals with developmental disabilities or dual diagnosis who are inpatients of the CAMH forensic program. The program aims to support successful transition to community housing supports in the developmental service sector. DD-TRHP is a unique program that is available only through direct referral by participating hospitals and is not accessible through the DSO. Individuals referred must also meet the eligibility requirements of the DSO. The program is funded jointly by the MOH and MCCSS. Other forensic hospitals in the province also have similar programs.

The FDDSS team collaborates with the inpatient forensic team and the developmental service housing service to support the transition to the community. FDDSS is responsible for overseeing all the aspects of care as it relates to risk management within the community (i.e., safety, risk of re-offense, reduction in recidivism, while also providing case management and psychiatric follow-up). The developmental service housing supports include activities of daily living skills, general care, and day-to-day programming. Length of stay in the DD-TRHP housing program is generally 18-24 months, following which individuals are transitioned within the developmental service sector to longer-term housing supports.

Example 3: Adapted and customized housing options

MCCSS-funded Developmental Service Organization

Reena is a faith-based community agency supporting individuals with developmental disabilities and their families from all denominations, and offers a variety of services including residential support, community participation supports, respite and outreach programs, and advocacy.

Reena is reviewing current housing options and locations within their portfolio for individuals with a dual diagnosis because the traditional group homes originally built for people with developmental disabilities are no longer suited to current needs. As opportunities arise, Reena relocates older individuals to more accessible housing, which in turn allows for the redevelopment of the original location. The redeveloped locations are chosen for suitability to house people with dual diagnosis or to be renovated to accommodate specific needs. Creating these redeveloped specialized environments also enables the training and development of a staff team with experience and expertise in dual diagnosis.

Reena has also custom-built locations for those individuals with extraordinary needs where a ground-up approach to design and development is required. In some circumstances, this involves working with clinical teams years in advance to understand the person's needs and how this translates into their ideal living environment. Some physical design elements include:

- Decreasing the number of individuals in the location to reduce possible issues with roommates and overstimulation, and accommodate for higher staffing ratios. For example, a triplex that would normally house seven or eight people (two 3-bedroom units and one 2-bedroom unit), may be decreased to five people (two 2-bedroom units and one self-contained apartment).
- Using mag locks as appropriate (within fire code and agency policies and procedures as well as MCCSS regulations).
- Soundproofing as needed.
- Modifying unused bedrooms (because of fewer roommates) into program spaces or enlarging a person's bedroom into a suite.
- Video in common areas.
- Staff communication system between units.

- Secure kitchens as needed that can also be used as a staff safety area with a computer, video feed and phone.
- Depending on the needs of individuals, renovate and enlarge bathrooms to include a larger tub, which can also be used to help meet sensory needs.
- Other physical design modifications include wall protection, inset lighting, and custom furnishings.

9.2 Staff advocacy and leveraging of cross-sector relationships

Many individuals with a dual diagnosis who are ALC have complex mental health and physical health challenges for which there is a small number of housing options available. Obtaining appropriate housing is often facilitated by establishing relationships where family members or staff can advocate for individuals.

Example 1: Hospital staff attend and support developmental service sector planning meetings

Hospital Inpatient Program

The Bayview Program for Dual Diagnosis at Waypoint Centre for Mental Health Care is a patient-centred specialty care program providing a range of services to individuals with a developmental disability and mental health needs.

The Bayview Program social worker attends developmental service sector Service Solution table meetings (local community meetings for long-term support planning for individuals with complex needs). Additionally the social worker meets quarterly with the MCCSS regional supervisor for forecasting purposes. Participation by hospital staff in this way helps considerably to increase understanding between the hospital, community, and funder, leading to accurate and timely information sharing regarding specific individual situations, which in turn accelerates decision-making regarding resource requirements and funding, as well as maintaining the needs of inpatients at the forefront.

Example 2: Advocacy and relationship building with the developmental service sector

Hospital Outpatient Program

The Community Mental Health Program at The Royal Ottawa Hospital offers specialized outpatient assessment and consultation services as well as intensive community support for individuals with a dual diagnosis.

Advocacy and relationship building with the developmental service sector occurs in various ways:

- Staff from the Royal Ottawa Community Mental Health Program attend the developmental service sector Pressures and Priorities table meetings (known as Service Solutions in some regions). This allows them to identify individual situations that can benefit from referral to the Royal Community Mental Health Program for assessment, consultation, or treatment. The Royal also offers psychological assessment reviews to situations that are brought forward to this table to help the community determine level of functioning or provide feedback regarding programming considerations and staff training.
- The director of the Royal Community Mental Health Program meets a few times a year or as needed with directors of the mental health inpatient units at The Ottawa Hospital to discuss dual diagnosis ALC patients, and brainstorm recommendations for discharge pathways and solutions through the developmental service sector (particularly in relation to housing). This also provides opportunities to support proposals to address service gaps for ALC clients.
- The Royal Community Mental Health Program periodically attends the Ottawa Developmental Services Network (ODSN), a meeting of executive directors of developmental service agencies committed to providing integrated service delivery through collaborative planning and partnerships. The Community Mental Health Program provides information and updates regarding the program as well as receives feedback relating to service barriers or community concerns.

Component 10: Sufficient and flexible funding

Dedicated funding is in place to support the transition period and to provide the necessary community housing and services to help individuals thrive and prevent re-hospitalization. Funding packages have flexibility to adapt to the complex and evolving needs of the individual.

Current state

Funding decision-making is generally not within the responsibility of hospital or community agencies. However, in all the practice examples noted above, hospital and community providers spoke of their involvement and support in the development and submission of funding applications so that individuals and families are not left on their own to find the necessary resources. There is also recognition among providers that sufficient and flexible funding to adequately support the transition from hospital, in addition to annualized funds/access to resources for housing and mental health supports, must be part of these packages. It is important to note that in addition to the time it may take to obtain appropriate housing (see ***Component 9***), receiving funding approvals can cause additional delays in transition planning and hospital discharges.

Organizations and contact information

If any contact information or links are no longer active, please visit the organization's website for up-to-date contact details.

Bethesda Services

Bethesda is a multi-service community agency for children, youth and adults with special needs providing access to a network of clinical supports and supportive living in the Southern Region of Brant, Haldimand–Norfolk, Hamilton and Niagara. Adult services include clinical treatment and therapeutic services, daily activities, recreation, leisure, and employment opportunities, supported living options, as well as serving as the lead agency for the Southern Network of Specialized Care.

Bethesda Adult Services
Liz Froese, Director, Adult Clinical Services
Phone: 905-684-6918 ext. 493
Email: lfroese@bethesdaservices.com

Canadian Mental Health Association, North Bay and District (Percy Place)

CMHA North Bay and District is a Mental Health, Addictions and Peer Support agency that specializes in support services to people with a serious mental illness.

Tara Lee Vaillancourt
Program Manager for Specialized Housing
Phone: 705-358-4730
Email: tvaillancourt@nbd.cmha.ca

Centre for Addiction and Mental Health (CAMH)

CAMH is Canada's largest mental health teaching hospital and a leading research centre affiliated with the University of Toronto. With more than 5,000 dedicated staff, CAMH offers outstanding clinical care to more than 38,000 patients each year, conducts ground-breaking research, provides expert training, develops innovative health promotion strategies, and advocates on public policy issues at all levels of government.

Melonie Hopkins
Transition Manager
Phone: 416-535-8501 Ext. 32739
Email: Melonie.Hopkins@camh.ca

Centre for Addiction and Mental Health, Adult Neurodevelopmental Services
An outpatient service providing short-term, interprofessional goal-oriented assessment and treatment to adults diagnosed with intellectual disabilities and/or Autism with mental health concerns and/or behaviours that challenge.

Mallory Ciminsky
Interim Manager
Phone: 416-535-8501 Ext. 30896
Email: Mallory.Ciminsky@camh.ca

Centre for Addiction and Mental Health (CAMH), Forensic Service - Forensic Dual Diagnosis Specialty Services (FDDSS)
FDDSS provides a range of services to both inpatient and outpatient CAMH forensic programs for individuals with suspected or confirmed intellectual and developmental disabilities. These services are available to those who are at least 18 years of age, are at risk of justice involvement or subject to a disposition under the Ontario Review Board (ORB); and/or have current or pending criminal charges, recent justice involvement, and/or are registered with the Forensic Early Intervention Service. Provided by a multidisciplinary team, these services include assessment, consultation, case management, transition planning, and system coordination.

Michelle Anbar-Goldstein
Social Worker
Phone: 416-535-8501 Ext. 33794
Email: Michelle.Goldstein@camh.ca

Community Networks of Specialized Care (CNSC)

There are eight accountable agencies in Ontario responsible for providing coordination to adults with developmental disabilities with high support and complex care needs in their region. The CNSCs are tied to developmental service agencies in each region. The following CNSCs are referenced in this report:

Community Networks of Specialized Care - Central East Region (CNSC-CE)
CLH Developmental Support Services
Marnie McDermott
Network Manager
Phone: 705-543-1749
Fax: 705-417-1781
Email: marnie.mcdermott@clhmidland.on.ca

Community Networks of Specialized Care - Eastern Region (CNSC-E)
Valor & Solutions
Daniel Fukumoto
Clinical Supervisor
Phone: 613-249-8593 Ext.4224
Fax: 613-249-0198
Email: dfukumoto@valorsolutions.ca

Community Networks of Specialized Care - North Region (CNSC-N)
Hands The Family Health Network
Stephanie Zacharuk
Network Manager
Phone: 705-384-5225 Ext. 2227
Email: szacharuk@handstfhn.ca or adultservices@handstfhn.ca

Southern Network of Specialized Care
Bethesda Services
Liz Froese, Director, Adult Clinical Services
Phone: 905-684-6918 ext. 493
Email: lfroese@bethesdaservices.com

Community Networks of Specialized Care - Toronto Region
Surrey Place
Bozena Sikora, Manager
Phone: 647-355-8361
Fax: 416-925-3402
Email: bozena.sikora@surreyplace.ca

Developmental Services Ontario

There are nine Developmental Services Ontario agencies across the province. The DSO is the access point for adult developmental services funded by the Ministry of Children, Community and Social Services (MCCSS) in Ontario. The DSO offices in this report include:

Developmental Services Ontario Hamilton-Niagara Region (DSO HNR)
Sarah Kupferschmidt (she/her)
Manager DSO HNR
Phone: 877-376-4674 Ext. 203
Email: sarah.kupferschmidt@dsohnr.ca

Individualized Planning Resource Development and Oversight (IPRDO), Community Living Fort Erie

The IPRDO is a provincial program providing planning and support resources to varying cohorts of individuals to develop transition plans to MCCSS Transfer Payment Agencies (TPA). The IPRDO may become involved when local TPAs do not have capacity to plan for those prioritized for housing on the DSO waitlist, or when there is a breakdown in existing arrangements and all other options have been exhausted. The IPRDO may facilitate housing in Outside Paid Resources (OPRs, private services funded on a daily rate) if appropriate, however these placements are temporary until resources become available within a TPA and/or a TPA has capacity to plan for the individual's needs.

Nikki Guyon-Boon
Senior Program Manager
Phone: 905-871-6770 ext. 272
Email: nboon@clfe.ca

Kerry's Place Autism Services

Kerry's Place serves children, adolescents, and adults with Autism Spectrum Disorder (ASD) and their families. Programs for adults are available in different regions of the province and include community services and supports, skill building and peer support groups, employment, and residential and semi-independent living support. A multidisciplinary clinical services team is available to individuals in the supported living programs.

Michael Morris
Manager of Service Connections
Phone: 289-221-9796
Email: Michael.Morris@kerrysplace.org

Ontario Shores Centre for Mental Health Sciences, Dual Diagnosis Program

Ontario Shores is a public teaching hospital providing a range of specialized assessment and treatment services to those living with complex and serious mental illness. The Dual Diagnosis Program is a specialized inpatient treatment program for individuals with a dual diagnosis.

Mark Rice
Administrative Director, Dual Diagnosis Program
Phone: 905-430-4055 Ext. 6648
Email: ricem@ontarioshores.ca

Options Northwest

Options Northwest is a non-profit organization that provides a range of services and supports to individuals with developmental disability/dual diagnosis in Thunder Bay and its surrounding district. These services may include residential, clinical, and community integration support.

Lisa Maki
Director of Clinical Services
Email: lisa.maki@optionsnorthwest.com

Providence Care Hospital

Providence Care Hospital provides rehabilitation, complex medical care, palliative care and mental health programs. The Adult Mental Health inpatient units support individuals who are 16 years of age or older, medically stable and have a primary diagnosis of severe mental illness.

Trudy Sickler
Social Worker
Phone: 613-544-4900 Ext. 53155
Email: sicklert@providencecare.ca

Reena

Reena provides support for 1,000 individuals with developmental disabilities and their families. Reena is a faith-based community agency supporting people from all denominations, and offers a variety of services including residential support, community participation supports, respite and outreach programs, and advocacy.

Sandy Stemp
Chief Operating Officer
Email: sstemp@reena.org

Sunbeam Developmental Resource Centre

Sunbeam offers a range of resources in southwest and central Ontario and works directly with hospitals to develop and implement Transition and Community Support Plans.

Sunbeam Community and Developmental Services
Tracy Erb
Director
Phone: 519-741-1121 Ext. 2229
Fax: 519-893-9034
Email: t.erb@sunbeamcommunity.ca

The Royal Ottawa, Community Mental Health Program

The Community Mental Health Program offers two outpatient programs: 1) the Regional Dual Diagnosis Consultation Team (RDDCT) provides specialized assessment and consultation to the community, as well as to inpatient units within the Royal and general hospitals within the Ontario Health Eastern Region; and 2) the Flexible Assertive Community Treatment Teams for Persons Dually Diagnosed (FACTT-DD) in Ottawa, Pembroke, Cornwall, and Brockville provide a continuum of community-based collaborative treatment approaches, from very intensive support during crises and acute illness (including collaboration with inpatient units during hospitalization) to less intense services during periods of stability.

Kate Baker
Director of Patient Care Services, Community Mental Health Program
Phone: 613-722-6521 Ext. 6579
Email: kate.baker@theroyal.ca

Vita Community Living Services

Vita Community Living Services offers a range of services in the Toronto and York regions, including residential supports, treatment and respite programs, community participation, and clinical and educational services. Vita offers integrated multidisciplinary supported-living clinical services to support the needs of adults with developmental disabilities and dual diagnosis with more complex behavioural and/or forensic histories.

Chanelle Salonia
Director of Clinical and Educational Services
Phone: 416-749-6234
Fax: 416-749-1456
Email: csalonia@vitacls.org

Waypoint Centre for Mental Health Care

Waypoint Centre for Mental Health Care is a specialty mental health hospital located in Penetanguishene. The hospital is home to the Waypoint Research Institute and has the province's only high secure forensic mental health program for clients served by both the mental health and justice systems.

Jennifer Schuler, Registered Nurse
Manager, Practice & Clinical Performance
Phone: 705-549-3181 Ext. 2295
Email: jschuler@waypointcentre.ca

Waypoint Centre for Mental Health Care, Bayview Program for Dual Diagnosis

The Bayview Program for Dual Diagnosis is a specialized inpatient treatment program for individuals with a dual diagnosis.

Michelle LaFraugh, Registered Nurse
Clinical Manager, Bayview Program for Dual Diagnosis and ECT Program
Phone: 705-549-3181 Ext. 2670/2150
Fax: 705-549-5084
Email: mlafraugh@waypointcentre.ca

Windsor Regional Hospital

Windsor Regional Hospital serves patients primarily from the Windsor and Essex regions, providing a range of health care services. It offers both inpatient and outpatient care and serves as a regional center for quaternary care for patients beyond its immediate vicinity.

Luke DiPaolo
Director for Mental Health and Allied Health Program
Email: Luke.DiPaolo@wrh.on.ca

Key definitions

Alternate level of care (ALC) → This is a term used in hospitals to describe patients who no longer require the level of care provided in that setting. Typically, patients are labelled as ALC because there is nowhere appropriate for them to be discharged to, so they remain in hospital. This term may be used in other settings to describe patients who are there inappropriately, such as a young person with Down syndrome living in a long-term care home or a person with a dual diagnosis who has completed treatment in a transitional treatment home. This report focuses on ALC patients in the hospital.

Community Networks of Specialized Care (CNSC) → The CNSCs provide direct complex coordination to adults with developmental disabilities with high support and complex care needs, including linking specialized services and professionals to collaborate and develop complex support plans. The CNSCs have geographic teams throughout Ontario and are housed in local MCCSS-funded developmental service agencies. Their services are typically accessed via referral to Developmental Services Ontario (see below). CNSC services vary by region but generally include complex support coordination, health care facilitation, dual diagnosis justice coordination, and case management.

Developmental disabilities → According to Ontario legislation, developmental disabilities is defined as including people who have "significant limitations in cognitive functioning and adaptive functioning and those limitations, (a) originated before the person reached 18 years of age; (b) are likely to be life-long in nature; and (c) affect areas of major life activity, such as personal care, language skills or learning abilities, the capacity to live independently as an adult or any other prescribed activity." This includes, for example, individuals with an intellectual disability, Autism, Down syndrome and fetal alcohol spectrum disorder (FASD). There are some conditions, such as Autism and FASD where a person may or may not meet the above criteria outlined in the provincial legislation, depending on the degree of limitations exhibited. Someone may meet criteria for a developmental disability according to the Ontario Disability Supports Program (ODSP) or child-based programs, but not to adult-based services supported by the DSO. This is because different sectors and programs have slightly different definitions.

Developmental Services Ontario (DSO) → DSO is the access point for all adult developmental services in Ontario that are funded by the MCCSS. To access developmental services in Ontario, a person must first demonstrate eligibility (confirmation of a developmental disability). If eligible, their support needs are assessed by the DSO and they are referred for services through one or more developmental service agencies which offer housing supports, specialized supports (e.g., case management, behavioural services, person-directed planning), community participation supports, caregiver respite supports

and funding programs. There are long wait times for some services, so it is important to ensure patients are connected with the DSO as early as possible.

Community health and developmental service provider → This refers to those the people who will provide ongoing support in the community following discharge. It includes health care providers outside the hospital inpatient unit who offer in-home and community-based care (e.g., primary care providers, personal support workers, psychiatrists, other specialist physicians, psychologists, behaviour therapists, social workers, nurses, occupational therapists, speech-language pathologists) and developmental service providers (e.g., direct support professionals, day programs, vocational support programs) funded within the developmental sector.

Direct support professional/worker (DSP) → DSPs are trained staff who work directly with people with developmental disabilities. Sometimes they are called direct support staff or developmental service workers (DSWs). They provide similar support to what is offered by personal support workers (PSWs) but there are important differences. The college-level DSW diploma is a two-year program whereas college-level PSW training is typically less than one year. In DSW training, there is greater emphasis on developmental disabilities, as opposed to disability generally, and ways to support someone to be included in their community.

Dual diagnosis → According to the 2008 Dual Diagnosis Joint Policy Guidelines, this refers to individuals who have "both a developmental disability and mental health needs". It is recognized that diagnosing psychiatric disorders in some people with developmental disabilities can be challenging, particularly when they have limited verbal communication.

Family → The term "family" is used broadly in this report to include family members, significant others, friends or other unpaid people who the patient defines as their family. Most of the patients addressed in this document rely on a support person and it is very important that whenever possible these individuals are included in transition planning. In cases when the patient has capacity to provide consent concerning their health care, consent must be obtained before engaging with the family member. Throughout this document, the recommendation to include family is based on the assumption that the patient has provided consent.

Family-centred care → Family-centred care recognizes the central role that families can play in supporting the patient. Family-centred care means ensuring that family members, as defined by the patient and with consent, are included in planning and decision-making related to the patient's care. It also means considering the care families need to support their own wellness and ongoing ability to support the patient (see also person-centred care).

Forensic mental health system → There are ten designated hospitals in Ontario that include forensic inpatient mental health units. These units contain individuals, including people with a dual diagnosis, who have been charged with a crime but deemed unfit to stand trial or not criminally responsible. People who have been declared unfit to stand trial or not criminally responsible are under the authority of the Ontario Review Board (ORB). The ORB conducts regular reviews to determine if the person should remain in hospital or if they should receive a conditional or absolute discharge. Individuals in these hospital units can become ALC if they receive a conditional or absolute discharge but there is no appropriate discharge setting. A conditional discharge means that the person can live in the community, but they continue to be under the supervision of the designated hospital. This means that once they transition to the community, the forensic team continues to be responsible for providing care until an absolute discharge is granted by the ORB.

Hospital team → This refers to the team of health care providers who provide support to the patient while they are on the inpatient unit. This may include nurses, social workers, psychiatrists, internist physicians, occupational therapists, speech-language pathologists, behaviour therapists, psychologists, neurologists, geriatricians and other health care providers.

Ontario Disability Support Program (ODSP) → ODSP provides an income source for eligible adults (age 18 years and above) with disabilities in Ontario.

Outside Paid Resource (OPR) → Outside Paid Resources (OPRs) are private organizations that may or may not be for profit. These organizations are directly funded and monitored by Transfer Payment Agencies and service agreements are signed between the parties.

Passport Program → The Passport Program provides reimbursement to eligible individuals up to a set limit for certain fee-based services (e.g., recreational programming, skill development, support worker or respite services). The program is funded by MCCSS and can be accessed through the DSO once eligibility is confirmed.

Person-centred care → Person-centred or patient-centred care means that planning and decisions regarding care are made collaboratively with the person based on consideration of their individual needs and preferences. Additional time and support may be required to ensure the person can be meaningfully included in the planning and decision-making process. For people with developmental disabilities, person-centred care often requires close collaboration with family members (see also family-centered care).

Quality Assurance Measures (QAM) → Ontario Regulation 299/10, under the Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008, the regulation on Quality Assurance Measures sets out the Ministry's expectations for how service agencies that support adults with a developmental disability provide services and supports.

Service Solutions → Accessed through the DSO, Service Solutions is a process for long-term support planning for individuals with complex needs. They are typically involved when existing resources are unable to provide services or are deemed inappropriate to mitigate risks, there are barriers to accessing the required support due to system gaps, and/or the individual is part of a priority target group.

Substitute decision-maker → In cases when a person lacks capacity to provide consent for their health care decisions, a substitute decision-maker is required. This person is often a family member or when family is not available, this service may be through the Ontario Office of the Public Guardian and Trustee. The Ontario Health Care Consent Act provides specific guidance about who can be the substitute decision-maker.

Transfer Payment Agency (TPA) → Community-based agencies funded by the Ministry of Children, Community and Social Services (MCCSS) to provide a range of services and supports to individuals including services for children and families, young offenders and persons with developmental or physical disabilities.

Transition period → This document uses the term "transition period" to include the periods before, during and after hospital discharge where additional planning and resources are needed to support the individual to live successfully in the community. The length of the transition period is unique to each individual.

Transition coordinator → The transition planning process should be led by clearly identified individuals from the hospital and from the community who have responsibility for planning and supporting the transition. In this document, these individuals are referred to as "transition coordinators". Depending on the availability and expertise of local staff, different types of staff may occupy this role. The hospital lead may be a designated discharge planner, a social worker or another member of staff. The community lead may be from a CNSC or they may be from the community agency who will provide housing.

Acronyms

ADL → Activities of daily living

ALC → Alternate level of care

CNSC → Community Networks of Specialized Care

DSO → Developmental Services Ontario

DSP → Direct support professional

DSW → Developmental service worker

FACTT → Flexible Assertive Community Treatment Team

MCCSS → Ministry of Children, Community and Social Services

MOH → Ministry of Health

ODSP → Ontario Disability Support Program

OHIP → Ontario Health Insurance Plan

OPR → Outside Paid Resource

ORB → Ontario Review Board

PRN → Pro re neta (as the need arises)

QAM → Quality Assurance Measures

TPA → Transfer Payment Agency

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We extend our sincere appreciation to all the health and social service providers who generously contributed to this report. The innovative practices profiled in this report from both the hospital and community sectors across Ontario offer valuable strategies that can help support patients with a dual diagnosis designated as alternate level of care to successfully transition from hospital to community.