INTO THE COMMUNITY AT LAST?

Report of the
Special Project for Systems Integration
a joint project of the Royal Ottawa Health Care Group and CMHA Ottawa

REPORT #2:
ISSUES RELATING TO INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Gerry Casey, M.S.W.
with the assistance of Lynnette Scobie

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Centre de santé mentale
RoyalOttawa
Mental Health Centre

CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

EXECUTIVE SUMMARY

The Special Project for Systems Integration was established by the Champlain Mental Health Network to assess the capacity of the current system of Ottawa based mental health services to facilitate the community placement of patients from specialized inpatient facilities who are ready for discharge. The findings and recommendations of the project are outlined in two reports: the first, entitled *Report #1: Issues Relating to Individuals with Dual Diagnosis* explores the unique dynamic faced by those with dual diagnosis and the extent to which appropriate, specialized, and adequate services are accessible and integrated between the developmental and health/mental health sectors; and the second, this report, which explores issues relating to the community integration of individuals with severe and persistent mental illness.

The project examined the extent to which Ottawa-based mental health services are appropriate, adequate, integrated, and recovery focused for individuals with severe and persistent mental illness. It conducted extensive research and consultations with stakeholders to develop a general profile of individuals with severe and persistent mental illness, to ascertain best practices for the community integration of these individuals, to identify systems issues in the Ottawa context that challenge the community integration of individuals with severe and persistent mental illness, and to make recommendations for operational improvements.

The profiling component of the research revealed a range of characteristics within the course of severe and persistent mental illness that pose significant challenges to an individual's community integration. These characteristics typically include fluctuating levels of symptom stability and acuity, a history of multiple hospitalizations, limited insight into the illness, periods of treatment resistance and medication non-compliance, a high incidence of co-morbid conditions such as substance abuse, personality disorders and primary medical conditions, impairments in psychological functioning, limits in problem solving and coping skills, and significant incidences of high-risk behaviours such as suicidal ideation, self-harm, fire setting, sexual acting out, and property damage. Consequently, individuals with serious and persistent mental illness have significant deficits in skills associated with the activities of daily living and with the ability to independently maintain goal-oriented activities. The overall need for supervision in residential placements is high, residential placement breakdowns common, and the risk of homelessness constant.

A literature review of evidence based principals revealed that support for the community integration of individuals with severe and persistent mental illness, and particularly those who struggle with the most chronic conditions, requires access to services that are specialized, that address a wide spectrum of needs,

and that are coordinated and integrated at both the program and individual treatment planning levels. This level of service is commonly referred to as 'tertiary care' and includes a system of specialized interventions delivered by highly trained staff in community and institutional settings that integrates elements of psychosocial rehabilitation, medication management and behavioural approaches. Tertiary care is not limited to one setting or time frame, but involves a range of specialized interventions that can be employed in institutional settings such as long term care homes, hospital inpatient and outpatient units, community residential programs, and through portable models of community intervention such as assertive community treatment and psychiatric outreach. Similarly, transition planning and continuity of care are integral to the process of reintegrating individuals in psychiatric inpatient settings to sustainable community placements and to effectively managing movement between these settings. Transition planning involves the management of a complex interface between consumers, institutions and community based service providers, emphasizing the need for continuity and quality of information exchange and collaborative treatment planning as the individual moves back and forth through the various parts of the health care system. Continuity of care requires active collaboration between stakeholders in program and service development and in individual treatment planning.

Most evident in the findings of the Special Project for Systems Integration was that the Ottawa-based mental health system does not have sufficient resources to support the tertiary care needs of individuals with serious and persistent mental illness. Consequently, individuals are often faced with limited options for service at stages in their recovery journey when they are most needed. Further, findings revealed that individuals with the highest complexity and acuity of symptoms and needs face the most significant challenges in accessing appropriate, specialized and individualized services.

The research also identified significant limitations in the ability of the current mental health service sysetm to facilitate continuity of care and transitional planning. The system currently lacks consistently applied, systems-wide mechanisms to facilitate multi-stakeholder consultation and collaboration. It also lacks appropriate resources within programs to ensure that best practice principles are operationalized. What results is a limited capacity for transitional planning and limited opportunities to facilitate person-centred and recovery focused service on a systems-wide basis.

Moreover, the Special Project for Systems Integration identified significant limitations in the system's capacity to facilitate appropriate residential placement for individuals with severe and persistent mental illness. The current system lacks the overall capacity to provide individuals with specialized and intensive residential support in secure community-based treatment environments when they are at the most acute and symptomatic stages of their recovery process. Further, access to all levels of housing support is impacted by a lack of adequate community-based recreational and vocational programming.

As a result, the recovery journey for many individuals with severe and persistent mental illness is often marked by inappropriate and inadequate residential supports and the constant risk of residential placement breakdown.

Based on these findings, the Special Project for Systems Integration offers a number of recommendations for systems enhancements to address the limitations within the current system surrounding service integration, transitional planning, community support, residential support, and community integration. Paramount is the recommendation that the Royal Ottawa Health Care Group enhance communication and collaboration across the system and involve the input of consumers and their families in the planning and treatment dynamic. The project also strongly recommends that the Champlain Mental Health Network play a leadership role in ensuring that individuals with severe and persistent mental illness have access to appropriate and affordable housing at all stages of their recovery process. Additional recommendations include enhancing the range of treatment modalities and community based programs available to individuals with severe and persistent mental illness; increasing knowledge across the continuum of mental health services related to the range of collateral programs available to individuals with severe and persistent mental illness; providing for the training needs of domiciliary care and community treatment staff; and providing for ongoing multi-sector collaboration to address limitations and facilitate system enhancements. A number of these recommendations can be achieved through targeted initiatives within existing resources. Several of the recommendations, however, require the infusion of significant additional resources into the mental health system. Strong leadership and advocacy in implementing these recommendations on the part of service programs across the spectrum of mental health services is required to ensure that Ottawa-based mental health services are appropriate, adequate, integrated, and recovery focused for individuals with severe and persistent mental illness.

ACKNOWLEDGEMENTS

The Special Project for Systems Integration gratefully acknowledges and appreciates the participation of the many systems stakeholders, from both inpatient and community settings, who contributed to its process. The level of support received bodes well for future endeavors in systems building.

The Special Project for Systems Integration greatly appreciates the support and guidance of Dr. Pamela Prince, of the Royal Ottawa Health Care Group, in the completion of this report.

Finally, the Special Project for Systems Integration wishes to express its gratitude to the consumers, peer advocates, and family members who participated in its activities. Their stories provided insight into the individual's journey of recovery and inspiration to work towards building a system of mental health services that supports that journey.

SUMMARY OF RECOMMENDATIONS

Community Integration and Access to Services	**That the Champlain Mental Health Network place a high priority on assessing the capacity of current community mental health services to support individuals whose complexity of needs and symptom acuity often preclude access to services. (p.13)**
	That service system developments include enhancements in the range of community treatment modalities available to individuals at all stages of their recovery process. **Further, that service system developments include investments to enhance resources for existing peer-support and consumer lead services, and to create new programming of this nature. The potential to increase the role of this type of service in the inpatient and community based system of supports should be a priority in systems planning. (p. 13)**
	That recreational, vocational and other community based programming for individuals with severe and persistent mental illness be made a priority for funding enhancements and multi-stakeholder collaboration and planning. (p. 13)
	That the general hospital system's ability to meet the crisis needs of individuals with severe and persistent metal illness be given a high priority for assessment and service enhancement. (p. 14)
Communication, Collaboration and Transitional Planning	**That the Champlain Mental Health Network explores opportunities for enhanced orientation of inpatient and community programs regarding the operational dynamics of collateral services and that a wide range of initiatives be considered including multi-stakeholder program information sessions, targeted print resources, and opportunities for staff to tour other programs and/or shadow program staff.** **Further, that planning involve multiple stakeholders from across the continuum of mental health services, including inpatient, primary health care, intensive community support and residential programs and that initiatives focus on enhancing knowledge of the mandate, services offered, access criteria and systems challenges faced by collateral programs. (p. 15)**
	That the Champlain Mental Health Network further explore the nature of client-based information sharing and treatment planning between mental health programs with a view to identifying mechanisms to enhance communication and collaboration. This process should include multiple stakeholders from the spectrum of mental health services. **Further, that initiatives include enhancements to communication and collaboration between inpatient and intensive community supports and other community programs such as residential services and drop-in centers and that these initiatives be seen as an opportunity to enhance the foundation for communication and collaboration between various levels of mental health services in preparation for the implementation of a common assessment tool. (p. 17)**

Communication, Collaboration and Transitional Planning *cont`d*	**That the Royal Ottawa Health Care Group place a high priority on enhancing current treatment planning mechanisms to improve transitional planning for individuals with severe and persistent mental illness who access services across the inpatient and community spectrums of care.** **Further, that the Royal Ottawa Health Care Group and the Champlain Mental Health Network place a high priority on applying the principles of collaborative care identified by the ROHCG/CMHA Ottawa shared care research project. (p. 18)**
	That the Royal Ottawa Health Care Group and Champlain Mental Health Network prioritize the development of concrete standards and accountability mechanisms for communication and collaboration with family members in the course of treatment planning. **Further, that the exploration of this issue include the input of inpatient treatment staff from Royal Ottawa Health Care Group and general hospital settings, family and patient advocates and community partners. (p. 19)**
	That the Royal Ottawa Health Care Group review all mechanisms for communication and collaboration in treatment planning with consumers in order to facilitate systems enhancements that ensure standards of practice and mechanisms that assure accountability. **Further, that this process involve inpatient treatment staff, the Client Empowerment Council, the Patient Representative, and Patient Advocate/Rights Advisors and that systems enhancements include concrete mechanisms to facilitate consumer involvement in treatment planning, and inpatient treatment practices and approaches that support client-empowering, recovery-oriented service. (p. 19)**
Housing Resource and Consumer Choice	**That the Champlain Mental Health Network play a leadership role in advocating for significant increases in financial support for individuals with severe and persistent mental illness receiving Ontario Works or Ontario Disability Support Program benefits. (p. 24)**
	That the Champlain Mental Health Network play a leadership role in advocating for significant increases in social housing and other forms of subsidized rental accommodations for individuals with severe and persistent mental illness. (p. 24)
	That the Champlain Mental Health Network provide leadership in addressing the housing needs of individuals with severe and persistent mental illness on a systems wide basis by: • **Advocating for significant investments to increase the capacity of community-based residential supports to provide service to individuals with the most complex and acute needs.** • **Facilitating the development of a systems wide network to explore issues regarding residential support capacity, opportunities to increase collaboration and integration, and to inform overall residential systems enhancements. Priority should be placed on enhancing residential services for individuals who are not adequately served by current residential supports.** **(*cont`d next page)***

	• **Facilitating ongoing collaboration between Homes for Special Care and Ottawa Housing's Domiciliary Care program to identify potential high support homes/beds, and to facilitate access to Homes for Special Care supports and resources for individuals requiring this level of support.** • **Exploring the possibility of developing an integrated mechanism to facilitate multi-stakeholder residential case planning for hard to serve consumers.** • **Providing leadership in the development of service enhancements to increase the capacity of long term care settings to provide service to individuals with severe and persistent mental illness. (p. 26)**
Domiciliary Hostel System	**That the capacity of current residential supports to provide single room accommodations be a priority item for discussion and planning with regards to systems wide enhancements in residential services. (p. 27)**
	That the Champlain Mental Health Network play a leadership role in initiating multi-stakeholder consultations to: • **Identify the training needs of domiciliary care staff and the systems issues that impact upon access to training.** • **Develop mechanisms to facilitate multi-stakeholder collaboration in the provision of training to residential staff that is accessible and sustainable.** • **Incorporate existing training initiatives in these developments. (p. 28)**
	That the Champlain Mental Health Network provide leadership in: • **Advocating for enhanced resources for the provision of activity and skill building programming in domiciliary hostel programs, and in other residential and community based settings** • **Facilitating planning between domiciliary care operators, other community-based residential support programs, CMHA and Homes for Special Care personnel, and others stakeholders in the development of collaborative activity-based programming for individuals with severe and persistent mental illness, capitalizing on potential efficiencies that can be found by sharing resources, facilitating shared transportation, etc.** • **Supporting domiciliary hostel providers in developing a mechanism to facilitate access to volunteer and student support in the provision of in-house programming to individuals with complex needs (p. 29)**

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LIST OF ABBREVIATIONS

ACTT	Assertive Community Treatment Teams
BMHC	Brockville Mental Health Centre
CMHA	Canadian Mental Health Association
CMHA Ottawa	Ottawa Branch of the Canadian Mental Health Association
CMHN	The Champlain Mental Health Network
CPIP	Crisis Prevention Intervention Program
DD Clinic	CMHA's Dual Diagnosis Community Clinic
DDCOT	Dual Diagnosis Consultation Outreach Team (of the Royal Ottawa Hospital)
FAWG	Family Advisory Working Group (of the Champlain Mental Health Network)
HSC	Homes for Special Care
ICM	Intensive Case Management
LHIN	Local Health Integrated Networks
MHCSS	Mental Health Community Support Services
OCTC	Ottawa Children's Treatment Centre
ODSP	Ontario Disability Support Program
OMCSS	Ontario Ministry of Community & Social Services
OMHLTC	Ontario Ministry of Health and Long Term Care
ROHCG	Royal Ottawa Health Care Group
ROMHC	Royal Ottawa Mental Health Centre
SSAH	Special Services at Home

INTRODUCTION

The recent announcement of the newly created Mental Health Commission of Canada brought significant media attention to the reality faced by individuals with mental illness in Canadian society. The Commission was born from recommendations of Senator Kirby's "Out of the Shadows at Last", and his national study on mental health, mental illness, and addictions (Senate, 2006). The Commission was established to bring national leadership to the development of an integrated mental health system that places people living with mental illness at its centre. For individuals living with mental illness, their family members and personal supports, and the professional programs that endeavor to serve them, the lack of an integrated, person-centred mental health system is a reality that lasts well beyond the point where media coverage ends. These groups have long been aware that the systems issues they face on a daily basis, in either accessing or providing mental health services, impact the individual's journey to recovery as profoundly as their individual diagnosis and illness. Although hope is to be found in greater recognition of this dynamic at legislative and policy development levels, the translation of hope into reality depends upon the infusion of required resources and the development of concrete mechanisms to enhance mental health systems functioning.

> ***"For those with severe and persistent mental illness, recovery and community integration are ongoing, life-long processes, and the journey is unique for each individual."***

For those with severe and persistent mental illness, recovery and community integration are ongoing, life-long processes, and the journey is unique for each individual. What is common, however, is the important role that appropriate, adequate, flexible, accessible, individualized and integrated mental health services plays in either supporting or confounding the recovery process. In the Ottawa context, the lack of an integrated, person-centred mental health system is reflected in the challenges faced by inpatient and community based mental health services in supporting the community integration and recovery of individuals with severe and persistent mental illness. Their cause may be coming out of the shadows, but a paradigm shift in supports available to them is required if they are to move into the community at last.

The Special Project for Systems Integration was established by the Champlain Mental Health Network to assess the capacity of the current system of Ottawa-based mental health services to facilitate the community placement of patients from specialized inpatient facilities who are ready for discharge. Its scope of inquiry examined the extent to which services are appropriate, adequate, integrated and recovery focused.

The project initiated extensive consultations with professional stakeholders, consumers, and family members to identify systems issues that confound the process of community integration for individuals with severe and persistent mental illness and make recommendations for operational improvements. These findings and recommendations are outlined in two summary reports: the first report, exploring the unique dynamic faced by individuals with dual diagnosis, and this report, addressing issues relating to the general population of individuals with severe and persistent mental illness. Some of the recommendations identified by the Special Project for Systems Integration can be achieved within existing resources. Most, however, require the infusion of significant additional resources into the support system. Many of the findings and recommendations have previously been identified in national and provincial studies and policy documents but have yet to be integrated. Strong leadership and advocacy in implementing these recommendations on the part of service programs across the spectrum of mental health services is required. Recognition of the need for change, and the identification of principles and practices to guide change are important, but ultimately, concrete action initiates change.

FORMAT OF THE REPORT:

This report, submitted to the Systems Table of the Champlain Mental Health Network, is organized as follows:

- **Executive Summary**: providing a general overview of the purpose, scope, and findings of Special Project for Systems Integration investigations.
- **Summary of Recommendations:** outlining all recommendations made and providing page-number references to the location of these recommendations in the body of the report.
- **List of Abbreviations:** providing readers with a central reference list for the terms and acronyms used in the report.
- **Background:** providing background to the inception of the Special Project for Systems Integration and its goals
- **Methodology:** outlining the project's methodology and scope
- **Findings/Discussions**: discussing the findings of Special Project for Systems Integration investigations and recommendations for systems enhancements.
- **Appendices:** providing a detailed overview of the data gathering activities of the Special Project for Systems Integration, templates of all the data gathering tools developed by the project, and a list of the evidence based research reviewed by the project.

BACKGROUND

THE CHAMPLAIN MENTAL HEALTH NETWORK AND MENTAL HEALTH REFORM

The Local Health Integrated Networks (LHIN) were created by the Ontario government in 2006 as not-for-profit corporations to work with local health providers and community members to determine health priorities in their identified districts. The Champlain Mental Health Network (CMHN) is charged with planning, coordinating, and making funding recommendations to the Ontario Ministry of Health and Long Term Care (OMHLTC) related to addictions and mental health services in the Champlain LHIN district. The membership of the Champlain Mental Health Network represents a wide range of system stakeholders. Its structure includes focus-specific work groups and a Systems Table, comprised of representatives from the work groups, that provides overall guidance and direction to the Network.

The Champlain Mental Health Network's mission statement commits to "working in partnership with mental health related networks to ensure the mental health system is a client-centered, recovery-based continuum of services that provides hope and dignity while improving the health and service satisfaction of the residents of the Champlain District" (CMHN, 2006, p. 1). CMHN's objective to strengthen the mental health system is guided by the principles of full and equitable representation and participation of consumer, family, and service provision stakeholders. Its activities include advocating at a systems level; supporting evaluation, education and capacity building; identifying systems wide needs and service gaps; and investigating innovative models that build on strengths and promote linkages among organizations, enhance communication and information sharing and develop links to facilitate service coordination and integration (CMHN, 2006).

The Champlain Mental Health Network has identified the following five high level priorities for systems development:

- A LHIN-wide recovery-oriented mental health system, honoring choice, self-determination and addressing the determinants of health, across the life span;
- Streamlined, coordinated access to an integrated system of services that welcome individuals and assist the consumer and their network to find and obtain (receive) appropriate services;
- Access to a continuum of suitable and affordable housing with the necessary support services to promote the retention of housing;
- The full continuum of services for special populations (dual diagnosis, concurrent disorders, geriatric psychiatry, borderline personality disorders, forensic) reflecting best practices and designed for special needs;
- Formal advocacy mechanisms to address individual, policy and system wide issues (CMHN, 2006).

CMHN considers the integration of services and system components to be a key factor in determining the capacity of the mental health system to support the community placement of individuals with serious and persistent mental illness. Integration implies coordination and collaboration between the wide variety of agencies and organizations that serve people with mental illness. It also implies that services are available and adequate to meet all needs (CMHN, 2006).

THE SPECIAL PROJECT FOR SYSTEMS INTEGRATION

The Special Project for Systems Integration emerged from discussions at the CMHN Systems Table regarding systems integration issues that impact the community placement of patients in specialized inpatient facilities who are ready for discharge and awaiting alternate levels of care. Informing the goals and scope of the Special Project for Systems Integration were discussions highlighting the challenges faced by the Royal Ottawa Health Care Group (ROHCG) in transitioning patients with severe and persistent mental illness, including the special population of individuals with dual diagnosis, from its inpatient units into Ottawa based community placements. Adopting CMHN's key principles and priorities for system development as a foundation, the Ottawa Branch of the Canadian Mental Health Association (CMHA) and the ROHCG assumed a leadership role in the development of the Special Project for Systems Integration. CMHA Ottawa and the ROHCG each seconded a staff member to act in capacity of co-leads for the one-year pilot project, which was launched in October 2006. The co-leads were supervised by members of the senior management of both the ROHCG and CMHA Ottawa. The project supervisors provided a direct link to the CMHN Systems Table and all project activities were vetted through, and guided by, the Systems Table.

The co-leads were charged with developing mechanisms to engage in consultations with key stakeholders and with completing reports identifying strengths, gaps, and opportunities related to service integration and the capacity of the current mental health systems to facilitate community integration of individuals with severe and persistent mental illness. The scope of inquiry for the project was limited to the Ottawa based mental health service system. Activities were focused one exploring issues that impact the capacity of the mental health system to facilitate transitional planning and community integration for individuals within its target populations, not on individual discharge planning. The target populations for the project's systems inquiry were individuals with severe and persistent mental illness receiving ROHCG inpatient care and/or intensive community based supports, including the special population represented by individuals with dual diagnosis.

METHODOLOGY

The Special Project for Systems Integration conducted a range of consultations and information gathering activities to identify strengths, gaps, and opportunities for service integration, transitional planning, and the capacity of the current Ottawa-based mental health system to facilitate the community placement of targeted populations of individuals with serious and persistent mental illness.

CMHN's five high-level priorities, mission, objectives and principles informed all aspects of the Special Project for Systems Integration's activities. The project was also informed by evidence based principles in discharge/transitional planning and community based service provision to individuals with severe and persistent mental illness, and individuals with dual diagnosis. Evidence based principles are practices and recommendations based on scientific knowledge, clinical experience and expert consensus.

The Special Project for Systems Integration undertook extensive research to identify issues relating to mental illness, dual diagnosis, and transitional planning and community integration. This included a review of documents regarding evidence based principles and key quality indicators in transitional/discharge planning, service integration, community support of individuals with serious and persistent mental illness, homelessness and mental illness, and the provision of support to individuals with a dual diagnosis. It also included a review of policy documents regarding mental health reform in the national and provincial contexts.

The project also initiated a range of activities to develop a general profile of individuals with severe and persistent mental illness and individuals with dual diagnosis. These activities included chart audits, interviews with inpatient social workers and community partners, and participation in multi-stakeholder case conferences regarding individuals with complex needs. This component of the research identified diagnostic and symptom factors relevant to the target population and their implications in terms of treatment and service needs, challenges to community placement, and risks of re-hospitalization. It revealed a composite profile of the individual characteristics and complex needs that present the most significant challenge to community integration initiatives for individuals with severe and persistent mental illness and dual diagnosis.

The Special Project for Systems Integration's exploration of mental health systems issues involved consultations with a range of consumers, advocates, and service providers. Information was gathered through a combination of interviews, questionnaires, focus groups, and participation in existing meetings, case conferences and committee activities. Inquiries included consultations with professional stakeholders who provide discharge planning, service coordination and brokerage, intensive case management and community support, residential care and other community based services. Interviews and questionnaires with

consumer and family advocates, and the facilitation of consumer focus groups were also performed. The focus of these consultations was to gain insight on discharge and transitional planning, information exchange, service provision and integration, access criteria for specialized services, capacity within the system and individual programs to address complex needs, and the extent to which consumers and family members are engaged as full participants in the treatment process. The consumer focus groups were developed in consultation with the Client Empowerment Council of the Royal Ottawa Mental Health Centre (ROMHC) and Psychiatric Survivors Ottawa. A detailed listing of the groups and individuals consulted by the Special Project for Systems Integration is included in Appendix A.

The Special Project for Systems Integration developed a number of tools to facilitate its information gathering activities. These included, among others, a *Chart Audit Tool*, *Residential Caregiver Interview Tool*, *Developmental Services Residential Caregiver Interview Tool*, *Consumer Focus Group Tool*, *Family Questionnaire*, *Community Support Program Interview Tool*, *Community Based Support Worker Questionnaire* and a *Social Work Staff Questionnaire*. The development of these tools was informed by evidence based research and the mental health reform priorities that guided the project. Templates of all the tools developed by the Special Project for Systems Integration are included in Appendix B.

SCOPE AND LIMITATIONS

The parameters of the project precluded the exploration of systems issues outside of the Ottawa region. As a result, there are significant issues impacting rural mental health services that did not fall within the Special Project for Systems Integration's scope of inquiry. As well, the project did not have access to services and programs within the general hospital system. Thus, ROHCG staff consultations were limited to social workers, patient representatives and patient advocates/rights advisors, and intensive community support and consultation programs.

The Special Project for Systems Integration explored general systems issues that have an impact on service provision to individuals with severe and persistent mental illness and individuals with dual diagnosis. There are unique issues impacting services to specialized populations beyond these target populations. The unique challenges faced by the geriatric and youth populations, those with addictions, individuals requiring multi-cultural interventions, and many other sub-groups did not receive focused exploration.

FINDINGS/DISCUSSION

The activities of the Special Project for Systems Integration were informed by evidence based principles in service integration, transitional planning, community integration, and residential support. This section discusses the project's findings with regards to the application of these principles in the Ottawa based mental health service system, focusing on barriers to operationalizing evidence based practice and recommendations for change. First, an overview of the primary characteristics of the target population of individuals with severe and persistent mental illness is provided.

TARGET POPULATIONS

The Special Project for Systems Integration initiated a range of activities to develop a general profile of individuals with serious and persistent mental illness whose journey in recovery and community integration is most challenging, and who represent the highest risk for re-hospitalization. These activities included chart audits, interviews with various stakeholders, and attendance at multi-stakeholder case conferences. While a clear constellation of individual characteristics and treatment dynamics emerged through this process, this does not suggest that individuals with severe and persistent mental illness are a homogeneous group. The extent to which the identified high-risk characteristics and resultant treatment dynamics are present varies from individual to individual and from one stage of the individual's recovery journey to the next. What is consistent is the extent to which these characteristics and dynamics, when present, impact on the capacity of the mental health system to support the individual's recovery and community integration.

One in five Canadians will be diagnosed with a mental illness that is significant enough to impair functioning, and three percent of those will suffer from a severe and persistent mental illness (CAMIMH, 2000). Although many individuals with severe and persistent mental illness can function effectively in the community with access to general psychiatric support and occasional interventions from general hospital psychiatric units, research has identified patient characteristics that interfere with the process of community integration and indicate a need for more specialized and intensive services (Christ, *et al.*, 1994; Wasylenki *et al.*, 2000). From a diagnostic standpoint, these characteristics are most commonly associated with chronic conditions such as depression, bipolar affective disorder, schizoaffective disorder and schizophrenia (Stein & Santos, 1998). These conditions are treatment resistant, often resulting in significant long term impairments that directly impact the individual's ability to maintain stable adjustment in the community. They also have important implications in terms of service usage (Stein & Santos, 1998).

In the Canadian context, individuals with a primary diagnosis of mental illness have a probability of hospital readmission that is 35 percent greater than those individuals with non-psychiatric primary diagnoses. Mood disorders and schizophrenic disorders make up almost half of the diagnoses in both general and psychiatric hospitals (CIHI, 2006). Ontario benchmarks for assertive community treatment services assume that 25 percent of individuals with severe and persistent mental illness will require intensive community support as a result of the complex challenges that characterize their illness (Wasylenki *et al.*, 2000).

In the Ottawa context, the characteristics identified by the Special Project for Systems Integration as posing the most significant challenges to the community integration of individuals with severe and persistent mental illness emerge from the interplay of positive and negative psychiatric symptoms, personal coping skills, and engagement with professional and personal systems of support. There is a high incidence of major mood and psychotic disorders. The course of illness typically includes fluctuating levels of symptom stability and acuity, a history of multiple hospitalizations, limited insight into the illness, periods of treatment resistance, and medication non-compliance. A high incidence of co-morbid conditions such as substance abuse, personality disorders and primary medical conditions is also common. Impairments in psychological functioning and limits in problem solving and coping skills are also prevalent. These impairments are often manifested in residential, social, and treatment environments by interpersonal conflicts, verbal and physical aggression, and difficulties with impulse control. There is also significant incidence of high-risk behaviours such as suicidal ideation and self-harm, fire setting, sexual acting out, and property damage. Individuals with serious and persistent mental illness have significant deficits in skills associated with the activities of daily living and with the ability to independently maintain goal-oriented activities. The overall need for supervision in residential placements is high, residential placement breakdowns common, and the risk of homelessness constant. Capacity to take part in vocational and recreational activities is often impaired resulting in significant financial and quality of life implications. Relations with peers, family, and social supports are often strained or non-existent. There is also a high degree of vulnerability to abuse, manipulation, and exploitation in community and social settings.

> ***"25% of individuals with severe and persistent mental illness will require intensive community support as a result of the complex challenges that characterize their illness."***

The incidence of these characteristics varies from individual to individual, and when present, the intensity varies over time. Their general prevalence is, however, such that they represent a constellation of characteristics and dynamics that are consistently associated with breakdowns in community

integration, barriers to accessing necessary supports, and overall failures on the part of the mental health system to provide adequate service. This characterization is not intended to negate the positive input that individuals with severe and persistent mental illness and their personal supports bring to the recovery process. These individuals are, first and foremost, survivors with a wealth of personal resources devoted to the recovery process. The challenge of an evolving mental health system is to work in conjunction with these individuals to develop mechanisms that address the challenges these individuals face, empower individuals to realize the full potential of their personal resources, and nurture hope and faith in recovery.

SERVICE INTEGRATION, TRANSITIONAL PLANNING AND COMMUNITY SUPPORT

Evidence Based Principles

Supporting the community integration of individuals with severe and persistent mental illness, and particularly those who struggle with the most chronic conditions, requires access to services that are specialized, that address a wide spectrum of needs, and that are coordinated and integrated at both the program and individual treatment planning levels. Streamlined, coordinated access to an integrated system of specialized and recovery-oriented mental health supports is a CMHN systems priority (CMHN, 2006). The capacity of mental health supports to provide this level of service is directly impacted by the array of supports available, the extent to which service development and delivery engages consumers as key participants, and the extent to which collaboration, co-operation, and communication between programs contributes to integration and a continuum of care.

The ability to access specialized, multi-disciplinary, multi-setting, mental health interventions is a significant determining factor for the community integration of individuals with the most serious impairments of chronic mental illness. This level of support is referred to as 'tertiary care'. Tertiary care is a system of specialized interventions, delivered by highly trained staff in community and institutional settings that includes elements of psychosocial rehabilitation, medication management, and behavioural approaches, (Wasylenki *et al*., 2000). Tertiary care integrates multiple disciplines and focuses on elements of recovery in a wide range of medical/psychiatric, psychological, and social/environmental life domains. Tertiary care is not limited to one setting or time frame but rather denotes a range of specialized interventions that can be employed in institutional settings such as long-term care homes, hospital inpatient and outpatient units, community residential programs, and through portable models of community intervention such as assertive community treatment and psychiatric outreach (Wasylenki *et al*., 2000).

Tertiary care is informed by the principles of psychosocial rehabilitation. These principles emphasize individually tailored interventions that are designed to involve the individual as an active participant in their own care, exploit their strengths, restore hope, facilitate environmental change to suit the capacities of the individual, and address a full array of social, vocational and recreational life concerns (Wasylenki *et al.*, 2000). The tertiary care model de-links levels of support from particular locations or time frames, directly providing some elements of specialized support and facilitating access to a range of other services across a range of settings. A mental health system with multi-setting tertiary care involves integrated and coordinated services that ensure a continuum of support across inpatient and community spectrums. As such, it facilitates access to specialized supports with interventions that are individualized and flexible to meet the evolving needs of the individual.

Effective community support of individuals with severe and persistent mental illness requires a high degree of integration and collaboration across the continuum of mental health services. An individual's capacities and needs change over time, present differently in various settings, and require coordination of interventions that maximize functioning. The maintenance of appropriate levels of flexible support provided by multiple stakeholders in varying settings, with overlapping levels of resource intensity, and the assurance of smooth transitions between levels of care in the service system, requires continuity of care (Sowers & Rohland, 2004). Continuity of care involves the active collaboration between stakeholders in program and service development and in individual treatment planning. While the individual pursues their journey of recovery, continuity of care assures that there is coordination between the services that they will access at various times and through various programs, that consistent linkages with key support persons are maintained across the spectrum of services, and that interventions remain individualized and responsive (Sowers & Rohland, 2004; Stein & Santos, 1998; Ware *et al.*, 1999).

> ***"Continuity of care involves the active collaboration between stakeholders in programs and service development and in individual treatment planning."***

Continuity of care is integral to the process of reintegrating individuals in psychiatric inpatient settings to sustainable community placements and to effectively managing movement between these settings. Inpatient treatment and discharge planning and the quality of collaboration and coordination between inpatient and community services has direct implications for continuity of care. The traditional terminology of discharge planning is not reflective of continuity of care as it reinforces the notion of discreet, independent treatment programs and implies a termination of service and responsibility. This can lead to conflicts between providers and the development of gaps in the service continuum (Sowers & Rohland, 2004). The concept of transition planning more

effectively establishes the parameters for intervention and collaboration required by continuity of care. Transition planning involves the management of a complex interface between consumers, institutions, and community based service providers. It emphasizes the need for continuity and quality of information exchange and collaborative treatment planning as the individual moves back and forth through the various parts of the health care system (OHCCC, 2004).

Transition planning requires the development of specific and standardized practices to ensure that its principles are translated into concrete action. A primary focus within these practices is multi-stakeholder communication and collaboration in the provision of comprehensive supports, as an assurance of responsibility and accountability (OHCCC, 2004; Sowers & Rohland, 2004). Transition planning begins at the time of admission to any level of care, is an integral component of the treatment plan, and encompasses all aspects of the individual's service needs (Sowers & Rohland, 2004). Transition planning identifies risk factors for community reintegration and incorporates those factors into treatment planning from the outset. The processes of initial assessment, treatment plan development, and facilitation of community reintegration incorporate relevant aspects of pre-existing treatment plans and involve the direct input and involvement of a variety of stakeholders, including the individual, their family and personal supports, family physicians, and multi-disciplinary inpatient and community based staff (OHCCC, 2004; Sowers & Rohland, 2004). Transition planning facilitates access to services across the continuum of mental health services, maximizes choice for service users, and ensures that there are clear protocols to delineate responsibility and assure accountability among specific stakeholders (Sowers & Rohland, 2004).

The Special Project for Systems Integration initiated a wide range of consultations and information gathering activities to assess the capacity of mental health supports in the Ottawa system to facilitate flexible, individualized, tertiary care across the spectrum of inpatient and community contexts. The extent to which services are integrated and coordinated was explored, with particular attention paid to the capacity of services to address the needs of individuals with the most complex and chronic needs. Transitional planning was assessed with a primary focus on levels of communication and collaboration between inpatient and community based services and between community partners. Also assessed was the extent to which transitional planning involved consumers and family members as active participants in treatment planning and implementation – processes that are recognized as key components in a recovery based system, A summary of the findings follow as they relate to community integration and access to services, and communication, collaboration and system planning,

Community Integration and Access to Services

Consultations with support services, including inpatient social workers and community based support programs, and with consumers identified concerns

regarding the range of specialized and generic supports available to facilitate transitional planning and community integration for individuals with severe and persistent mental illness. Primary concerns related to resource availability, service models, and access criteria.

Stakeholders reported that current systems of community based services are designed for individuals with mental illness who are relatively functional in community contexts, have some level of insight into their condition, and are motivated and capable of actively engaging in the development and implementation of treatment plans. This holds true across the spectrum of services, from drop-in centre programs to intensive community treatment supports. Intensive community treatment supports have a greater capacity to address chronic and complex needs. They can also attempt to support the individual throughout their stages of symptom acuity. This capacity deteriorates, however, as acuity impacts insight into illness, capacity to engage in treatment planning, and overall community functioning. Individuals with the most complex needs, who often lack insight into their illness and are treatment and medication non-compliant at the most acute stages of their recovery, have the most difficulty accessing and maintaining community based supports.

Professional stakeholders expressed concerns regarding the impact of limited resources on the range of services within their programs, and on the accessibility of services offered. Individuals with the most complex needs are those most impacted by limitations in program resources. Of most concern to these stakeholder were:

- Length of waiting lists for accessing intensive community support services.
- Difficulty accessing primary medical care, general practitioners, and in-home personal care supports through Community Care Access Centres.
- Limitations in community based recreational and vocational programming.
- Limitations in community based supports such as community kitchens, drop-in centers and club-house programs.
- Limitations in housing resources (explored in more detail later in this report).

Consumers identified the need for a greater range of treatment modalities in both inpatient and community contexts. Important to many individuals with severe and persistent mental illness were: increased access to a larger variety of individual and group therapies, therapeutic activity programming, and alternative approaches to maintaining wellbeing. Consumers also identified the need for more inclusion of peer-support mechanisms at all levels of inpatient and community treatment, calling for resource enhancements for existing peer support programs, and significant investments to establish new programming of this nature.

Consumers further recognized that the ability to engage in recreational and goal-oriented activities is important for quality of life and recovery. The limited capacity of many community support resources, and particularly those that are recreational, vocational, and/or skill building in their focus, to accommodate those with the most complex need and/or offer services that are time limited is of concern to many consumers. Similarly, they see participation fees and transportation costs associated with accessing these programs as a significant barrier to participation.

RECOMMENDATION #1:
COMMUNITY INTEGRATION AND ACCESS TO SERVICES

That the Champlain Mental Health Network place a high priority on assessing the capacity of current community mental health services to support individuals whose complexity of needs and symptom acuity often preclude access to services.

RECOMMENDATION #2:
COMMUNITY INTEGRATION AND ACCESS TO SERVICES

That service system developments include enhancements in the range of community treatment modalities available to individuals at all stages of their recovery process.

Further, that service system developments include investments to enhance resources for existing peer-support and consumer lead services, and to create new programming of this nature. The potential to increase the role of this type of service in the inpatient and community based system of supports should be a priority in systems planning.

RECOMMENDATION #3:
COMMUNITY INTEGRATION AND ACCESS TO SERVICES

That recreational, vocational and other community based programming for individuals with severe and persistent mental illness be made a priority for funding enhancements and multi-stakeholder collaboration and planning.

Both consumers and community stakeholders expressed concerns regarding the capacity of general hospital emergency units to address the needs of individuals who arrive with a mental health related crisis. A key concern was that individuals being triaged often have to wait in public areas for long periods of time while in distress. The emergency unit triage and treatment model is not designed to meet the needs of individuals with severe and persistent mental illness. Further, community stakeholders, including intensive community

support programs and residential care providers, expressed concerns regarding limited consultation with emergency personnel when they are supporting clients receiving emergency unit interventions. Also noted was that for chronic consumers of emergency response services, the closure of the Royal Ottawa Hospital psychiatric emergency unit resulted in the loss of a therapeutic relationship with emergency personnel.

Although the mental health services provided through the general hospital system were beyond the scope of the Special Project's for Systems Integration, concerns regarding the capacity of that service system to meet the crisis needs of individuals with severe and persistent mental illness were reported by a number of groups consulted. Accordingly, the Special project for Systems Integration recommends:

RECOMMENDATION #4:
COMMUNITY INTEGRATION AND ACCESS TO SERVICES

That the general hospital system's ability to meet the crisis needs of individuals with severe and persistent metal illness be given a high priority for assessment and service enhancement.

For issues related to community integration and access to services, the findings of the Special Project for Systems Integration reveal that individuals with the highest complexity and acuity of symptoms and needs face the most significant challenges in accessing appropriate, specialized and individualized services. Service providers reported limitations in their ability to support individuals who lack insight into illness and the capacity to engage in treatment planning. The capacities of intensive services, which are better placed to support the individual, are often exceeded. The current mental health system does not have sufficient resources in terms of the availability of specialized and intensive services, or in terms of general capacity to facilitate flexible, individualized, tertiary care across the spectrum of inpatient and community contexts. As a result, individuals are often faced with limited options for service at those stages in their recovery journey when they are most needed.

Communication, Collaboration and Transitional Planning

The Special Project for Systems Integration consulted with consumers, family members, inpatient social workers, community residential caregivers, and intensive case management and community treatment personnel to explore the quality of consultation and collaboration in treatment and transitional planning across the spectrum of mental health supports. Although there was universal acknowledgement of the importance of communication and collaboration and the recognition of the role each program has to play in facilitating information sharing, a number of concerns emerged regarding the capacity of the current system to operationalize these principles.

A number of concerns were identified regarding the overall level of knowledge various program personnel have in terms of the mandates, services offered, and access criteria of collateral services:

- Inpatient social work staff were concerned with the expectations community partners have of their capacity to facilitate inpatient admissions at times of community placement breakdown, and of their capacity to provide ongoing support to individuals following community integration.
- Community based program staff expressed concerns regarding the expectations inpatient personnel have of the level of resources community workers are able to draw upon when supporting complex-needs individuals in community settings, both in terms of the supports their individual agencies provide and the community services to which they are able to facilitate access.
- Residential caregivers, and particularly domiciliary hostel operators, reported that community partners have a lack of awareness of the limited capacity that their model of care has to provide intensive supports to complex needs individuals.
- Inpatient social workers identified the need for more information regarding the service mandate and capacity of individual domiciliary care programs.
- Multiple stakeholders expressed unease with the level of knowledge domiciliary hostel staff have of the range of supports that are available in the community, access criteria and referral mechanisms.

Orientation initiatives for inpatient and community programs offer an opportunity to enhance not only service system knowledge among these various stakeholders, but also to explore opportunities to improve the overall working relationships between various levels of the mental health service system. Accordingly, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
COMMUNICATION, COLLABORATION & TRANSITIONAL PLANNING

That the Champlain Mental Health Network explores opportunities for enhanced orientation of inpatient and community programs regarding the operational dynamics of collateral services and that a wide range of initiatives be considered including multi-stakeholder program information sessions, targeted print resources, and opportunities for staff to tour other programs and/or shadow program staff.

Further, that planning involve multiple stakeholders from across the continuum of mental health services, including inpatient, primary health care, intensive community support and residential programs and that initiatives focus on enhancing knowledge of the mandate, services offered, access criteria and systems challenges faced by collateral programs.

Concerns were also identified by the various stakeholders regarding the quality and consistency of communication between service programs as they relate to consumer strengths/needs and treatment planning:

- Residential caregivers identified concerns with the level of information they receive regarding individuals entering their programs. They indicated the need for more detailed information regarding physical/medical care needs, psychiatric symptoms, psychosocial history and overall treatment plan dynamics from both inpatient staff and community based support services. These stakeholders indicated that while there are occasions where in-depth information is received, there is inconsistency in terms of the general level of information provided.
- Inpatient and community support staff expressed concerns regarding limited knowledge on the part of direct care workers in community residential settings, and particularly domiciliary hostel programs, in regards to the strengths, needs, and treatment dynamics for individual residents. This concern relates to situations where support staff believed that adequate information had been communicated to residential programs but not integrated into treatment planning.
- Personnel from drop-in centre/club-house programs indicated that they are not adequately involved in consultations regarding complex needs individuals who attend their programs. Staff indicated that they require more information to properly serve these individuals, and that they are generally not asked to provide feedback to the treatment planning process. This gap in communication applies to both the inpatient and community based treatment contexts.
- Intensive community support staff, and particularly those from assertive community treatment (ACT) teams, identified the need for more detailed physical and medical health care information for individuals transitioning from inpatient care to the community. Access to neuropsychiatric, occupational therapy, addictions, and other specialized assessments was identified as specific areas of concern.
- Inpatient social work staff indicated that there are role duplications with regards to the assessments and other processes completed by inpatient and community based case management services.

The Ministry of Health and Long Term Care (OMHLTC) is in the process of developing a common assessment tool for use by all community mental health providers. The goal of this initiative is to establish standard definitions and processes for gathering and disseminating client assessment information. The tool will facilitate the sharing of client-consented information between programs, reduce repetitive information gathering, inform planning and promote best practices. Accordingly, the Special Project for Systems Integration recommends:

RECOMMENDATION #2:

COMMUNICATION, COLLABORATION & TRANSITIONAL PLANNING

That the Champlain Mental Health Network further explore the nature of client-based information sharing and treatment planning between mental health programs with a view to identifying mechanisms to enhance communication and collaboration. This process should include multiple stakeholders from the spectrum of mental health services.

Further, that initiatives include enhancements to communication and collaboration between inpatient and intensive community supports and other community programs such as residential services and drop-in centers and that these initiatives be seen as an opportunity to enhance the foundation for communication and collaboration between various levels of mental health services in preparation for the implementation of a common assessment tool.

Various community based stakeholders further expressed concerns regarding their level of involvement in the admissions, treatment, and discharge planning processes in ROHCG and general hospital settings:

- Many stakeholders reported inconsistency in their level of involvement in the admissions process and in ongoing inpatient treatment and community integration planning. While there are isolated incidents of quality communication and collaboration, this is not consistent enough to be a dependable systems feature.
- Special Project chart audits and stakeholder consultations showed limited application of transitional planning contracts that concretely identify the specific roles of various stakeholders in supporting community integration and that establish mechanisms to ensure accountability.
- Both inpatient personnel and community stakeholders expressed concerns regarding the impact of ROHCG and general hospital policies and protocols on the capacity of community personnel to provide on-site support to treatment initiatives.
- All stakeholders consulted recognized, in principle, the importance of involving multiple stakeholders in transitional planning. However, there remained widespread concern regarding the impact of limited levels of ongoing collaboration on the capacity of the system as a whole to engage true transitional planning and continuity of care.

The ROHCG and The Canadian Mental Health Association, Ottawa Branch, (CMHA Ottawa) are currently engaged in a research project evaluating the efficacy of a collaborative care model of transitional planning for individuals with severe and persistent mental illness who are hard to serve and at risk of poor physical and mental health outcomes. The research report *Evaluating Shared Care Between the Canadian Mental Health Association and the ROHCG*

Evaluation Unit explores concrete processes that underlie a 'shared care' model of transitional planning, and specific mechanisms for facilitating communication and collaboration between inpatient and community services at all stages of service delivery. Hence, the Special Project for Systems Integration recommends:

RECOMMENDATION #3:

COMMUNICATION, COLLABORATION & TRANSITIONAL PLANNING

That the Royal Ottawa Health Care Group place a high priority on enhancing current treatment planning mechanisms to improve transitional planning for individuals with severe and persistent mental illness who access services across the inpatient and community spectrums of care.

Further, that the Royal Ottawa Health Care Group and the Champlain Mental Health Network place a high priority on applying the principles of collaborative care identified by the ROHCG/CMHA Ottawa shared care research project.

Consultations with the family members of individuals with severe and persistent mental illness identified significant concerns regarding levels of communication and collaboration in the inpatient treatment planning process. Specifically:

- They are generally not provided with adequate information, nor are they effectively included in the admissions, treatment and transitional planning processes of ROHCG and general hospital inpatient facilities.
- While there are isolated incidents of engaged communication and collaboration, there is an overall lack of consistency in this regard. Many perceive that the level of communication and collaboration is more a function of individual personnel than it is of inherent systems features.
- They are often provided with inadequate information regarding their loved one's condition, course of treatment, and mental health resources available to support recovery. As well, they are not invited to share relevant information and expertise in the treatment planning process.

Family members expressed the desire to be considered "part of the team" in planning and implementing treatment for their loved-ones. Many believe the current system creates an 'us versus them' dynamic between family members and inpatient treatment personnel.

Consultations with consumers, consumer advocates, ROHCG patient representatives, and patient advocate/rights advisors identified additional concerns regarding the level of communication and collaboration with consumers in the ROHCG admissions, treatment and transitional planning processes. While information regarding psychiatric issues and treatment models are provided to consumers at the admissions, treatment, and community integration planning stages, the form and timing of this communication often does not facilitate adequate understanding as the impact of symptom acuity and other cognitive issues on the capacity of the individual to understand and participate is not

taken into account. Patient advocates report a low overall level of understanding and involvement for patients in all stages of treatment and transitional planning. They suggest that inpatient treatment planning processes are designed to meet the needs of treatment staff and are not empowering for patients.

RECOMMENDATION #4:

COMMUNICATION, COLLABORATION & TRANSITIONAL PLANNING

That the Royal Ottawa Health Care Group and Champlain Mental Health Network prioritize the development of concrete standards and accountability mechanisms for communication and collaboration with family members in the course of treatment planning and that the exploration of this issue include the input of inpatient treatment staff from Royal Ottawa Health Care Group and general hospital settings, family and patient advocates, and community partners.

Consumers confirm low levels of understanding surrounding the issues and processes involved in treatment planning. They perceive their level of involvement in treatment planning to be determined more by the personal approach of individual treatment staff than by factors inherent in the inpatient treatment dynamic. As a result, consumers see their level of involvement in treatment planning as being inconsistent and unpredictable. This leads to an "us versus them" dynamic and has a negative impact on the quality of the therapeutic relationship that they are able to establish with treatment staff. Consumers do not feel that their input and opinions are given serious consideration and, as a result, they are often mistrustful when communication and collaboration is engaged. For consumers, ineffective consultation and collaboration results in a lack of sufficient understanding of treatment options, medication effects and side effects, and the extent of their rights to refuse treatment. Consumers call for better transitional planning engaging both family and professional systems of support and for more integrated follow up support when they leave the inpatient setting for community placements.

RECOMMENDATION #5:

COMMUNICATION, COLLABORATION & TRANSITIONAL PLANNING

That the Royal Ottawa Health Care Group review all mechanisms for communication and collaboration in treatment planning with consumers in order to facilitate systems enhancements that ensure standards of practice and mechanisms that assure accountability.

Further, that this process involve inpatient treatment staff, the Client Empowerment Council, the Patient Representative, and Patient Advocate/Rights Advisors and that systems enhancements include concrete mechanisms to facilitate consumer involvement in treatment planning, and inpatient treatment practices and approaches that support client-empowering, recovery-oriented service.

In the course of the consultations, concrete examples of potential enhancements to communication and collaboration with patients were identified. These include:

- Current initiatives on the part of the ROHCG and the Client Empowerment Council to develop admissions information packages and mechanisms to disseminate information on an ongoing basis.
- The provision of information regarding symptoms, treatment interventions and operational procedures on multiple occasions, by a variety of individuals, using a variety of print and verbal communication strategies.
- Facilitating greater communication between the Patient Representative and/or Patient Advocate/Rights Advisor and treatment staff to determine patients' level of readiness to engage in communication and collaboration, and to establish the most appropriate time and means of facilitating communication.
- Facilitating an increased role for peer support workers and consumer advocates in the communication process.

The findings of the Special Project for Systems Integration call into question the extent to which the current system of mental health services is able to facilitate integration and collaboration in transitional planning. Lack of knowledge of the operational dynamics faced by partner agencies, and inconsistency in communication and collaboration in treatment planning between inpatient and community programs are significant barriers to transitional planning. Consumers and family members are unsatisfied with the extent to which they are engaged as active partners in the treatment planning and implementation process. There are situations where multi-stakeholder consultation collaboration is engaged and includes consumer, family, inpatient and community based service input. There is also widespread acceptance, by all stakeholders, of the importance of collaboration and communication in transitional planning. What the system lacks are consistently applied, systems wide mechanisms to facilitate this level of service integration and appropriate resources within programs to ensure that best-practice principles are operationalized. What results is a limited capacity for transitional planning, and limited opportunities to facilitate person-centred and recovery focused service on a systems wide basis.

RESIDENTIAL SUPPORT AND COMMUNITY INTEGRATION

Evidence Based Principles

Access to affordable, appropriate, and sustainable housing is widely recognized, in the Canadian and international context, as a basic human right and a key factor in the maintenance of individual mental health and healthy communities. The development of adequate resources and policy frameworks to facilitate access to appropriate housing for individuals with severe and persistent mental illness are key directives for mental health reform in the national, provincial, and Champlain LHIN. The capacity of the existing system to facilitate access to appropriate housing was an important area of focus for the Special Project for Systems Integration.

In principle, the housing options that individuals with severe and persistent mental illness have access to are wide ranging and include open market rental and owned housing, municipal social housing, housing with rent supplements administered by community mental health agencies, and a range of supportive housing models with varying degrees of transitional and rehabilitative programming. In reality, the ability of individuals with severe and persistent mental illness to access housing along this continuum is often limited by factors related to poverty, nature and acuity of illness, and limitations in support resources. An understanding of the interplay between housing and mental health and of the complex and varied housing needs of individuals with severe and persistent mental illness is a necessary precursor to appropriate systems development.

Many of us enjoy a personal standard of housing that represents more than a roof over head and shelter from the elements. Housing is synonymous with the concept of 'home': a place of safety, security, sanctuary, and a dependable base from which we pursue happiness and quality of life. Home is a place of empowerment where we are least restricted in our right to exercise self direction and self determination. We choose, within realistic limitations, where we live, with whom we live, and how we live. Our sense of home and our sense of mental health, or "the capacity of each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face" (CIHI, 2007, p. 3), are intertwined. Yet, for individuals with severe and persistent mental illness, accessing affordable, safe, appropriate, and sustainable housing is fraught with systemic barriers and discrimination. Access to basic shelter can be challenging. Finding a place to call home can be particularly difficult.

There is a dynamic interplay between mental illness and housing that has significant implications for the community integration of individuals with severe and persistent mental illness. Access to appropriate housing, with a complementing range of individualized professional and personal supports, has direct implications for the individual's ability to engage with needed support and maintain mental health in their ongoing journey of recovery (CIHI, 2007; Kell & Peace, 2002; Lightman, 1997; Nelson & Peddle, 2005). However, many of the

factors that impact the individual's recovery, including the extent of insight into the nature of the illness, engagement with treatment, availability of professional and personal supports, nature and acuity of symptoms, incidence of co-morbid conditions such as substance abuse, levels of daily stress, and range of coping skills have significant implications for their ability to access and sustain appropriate housing (CIHI, 2007; Kell & Peace, 2002). As a result of these compounding factors, the individual is often faced with the challenge of attaining a level of wellness to gain and sustain access to housing and community integration, while having limited access to forms of housing and support that are considered most conducive to their recovery. Increasing levels of illness lead to decreasing access to appropriate housing. (Kell & Peace, 2002).

Concepts of community support for individuals with severe and persistent mental illness have evolved since the early stages of deinstitutionalization in the 1960s, with increased emphasis on recovery, consumer choice and control, and community integration (CIHI, 2007). The 1970s marked the evolution from custodial housing, with a limited range of staffing support and a primary focus on custodial care, to supportive housing, with enhanced on-site staffing to provide varying degrees of case management, support, and rehabilitative programming (Nelson & Peddle, 2005). With supportive housing, individuals are assessed in terms of their support needs and referred to housing programs, typically communal living environments such as group homes or supervised apartments, with built-in supports to meet the level of need. The supportive housing model has been criticized for providing the individual with limited choice over where and with whom they will live, for clustering large numbers of individuals with severe and persistent mental illness in one setting, and for requiring the individual to move to a less supervised residential setting if they show improvements in community functioning (Nelson & Peddle, 2005).

Accessing affordable, safe, appropriate, and sustainable housing is fraught with systemic barriers and discrimination. Access to basic shelter can be challenging. Finding a place to call home can be particularly difficult

More recent developments have seen a conceptual shift to a 'housing first', supported housing approach. With this approach, the individual finds a place to live that is self-chosen and socially integrated and then individualized, flexible, and responsive supports are provided to the individual (US Surgeon General, 2001). The supports are de-linked from the residential site and are often provided by community based services such as assertive community treatment, intensive case management, and home support services. Although supported housing can occur in group living settings, in principle, it more readily supports independent living environments such as individual apartments. Many supportive housing models have taken on components of supported housing and,

particularly in the case of group living environments, the line between supportive and supported housing has become blurred (Nelson & Peddle, 2005).

The extent to which housing is conducive to mental health and recovery for individuals with severe and persistent mental illness is determined by the extent to which it is both appropriate and sustainable. Appropriate housing exists in a framework that provides the individual with choice and control (Nelson & Peddle, 2005). It facilitates access to a range of housing options, in terms of type and location, and the ability to exercise choice based on individual and evolving desires and needs. With appropriate housing, the choices available meet standards identified by the individual including: the physical nature and quality of the home; the degree of independence and/or support it provides; the opportunity for privacy and/or social interactions; the extent to which housing is shared with other individuals with mental health difficulties; and its location in relation to professional, community, and social resources (Kell and Peace, 2002; Linney & Arns, 1995; Nelson & Peddle, 2005). For appropriate housing, mechanisms must be in place to ensure that the individual has adequate financial resources to access housing of choice, within reasonable parameters (Kell and Peace, 2002; Nelson & Peddle, 2005). The sustainability of appropriate housing is contingent upon a system that ensures access to financial, professional, and social resources that are tailored to the individual's changing desires and needs and are available across the continuum of housing settings with which the individual chooses to engage (Kell and Peace, 2002; Nelson & Peddle, 2005). No one model of housing will meet the desires and needs of all individuals, or of one individual throughout their course of recovery. Access to a range of options that reflect the principles of appropriateness and sustainability is the key.

The Special Project for Systems Integration initiated a range of consultations with inpatient social workers, community stakeholders, and consumers to identify systems issues related to the capacity of the current system to facilitate access to appropriate residential supports for individuals with severe and persistent mental illness. The project focused on the extent to which community based residential resources facilitate access to appropriate and sustainable support mechanisms for community integration. Particular attention was placed on the capacity of residential supports to address the needs of individuals at the most complex and acute stages of their recovery process. All groups consulted reported limitations in the system's capacity to facilitate appropriate residential placement for individuals with severe and persistent mental illness. This negatively impacts community integration for individuals with severe and persistent mental illness.

Housing Resources and Consumer Choice

In Ottawa, individuals with severe and persistent mental illness face challenges in exercising choice in type and location of accommodations. Housing that supports independence and privacy – the housing of choice identified by most of

the consumers consulted – is the most challenging resource to secure. Consumers further reported that they often face discrimination and stigma with regards to their mental illness when attempting to secure independent private market rental accommodations. They also face challenges in accessing both supportive and supported models of housing. These challenges are attributed to factors relating to personal financial resources, housing availability, and acuity of mental illness.

Consumers have limited monthly financial resources to devote to private market housing costs. The primary source of income for the population examined by the project was either Ontario Works or Ontario Disability Support Program (ODSP) benefits. The Ontario Works benefit, for a single person, is $548.00 per month; ODSP provides $979.00 per month. The average rent for a bachelor apartment in Ottawa in 2006 was $633.00 per month (Alliance to End Homelessness, 2007). Based on these figures, single accommodations rental costs alone can account for between 64.7 percent and 115.5 percent of an individual's income, far above the 30 percent recommended by nationally accepted housing standards. Moreover, access to rental supplements administered by the City of Ottawa, Canadian Mental Health Association Ottawa and other community groups, is limited by supply and is often subject to prohibitive waiting lists. The waiting list for Ottawa social housing in 2006 was over 10,000 households, with wait times of up to eight years.

Accordingly, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
HOUSING RESOURCES AND CONSUMER CHOICE

That the Champlain Mental Health Network play a leadership role in advocating for significant increases in financial support for individuals with severe and persistent mental illness receiving Ontario Works or Ontario Disability Support Program benefits.

RECOMMENDATION #2:
HOUSING RESOURCES AND CONSUMER CHOICE

That the Champlain Mental Health Network play a leadership role in advocating for significant increases in social housing and other forms of subsidized rental accommodations for individuals with severe and persistent mental illness.

Issues that relate to acuity of mental illness have a significant impact on housing settings that are accessible to individuals with severe and persistent mental illness. The impact of symptoms and the resulting impairments in personal care and daily living skills, personal safety skills, interpersonal skills, insight into

illness, and the ability to engage in structured interventions often limits the housing settings to which the individual has access. For those with the most complex and acute needs, maintaining independent housing is often beyond the individual's capacity, even when combined with rental supplements and intensive community supports. Access to rehabilitative supportive/supported housing is limited by criteria that require a certain level of daily living skills, communal living abilities, and capacity to engage in rehabilitative and skill building activities. These may not be permanent limitations for all individuals, as the journey to recovery often involves movement along a continuum of symptom intensity. However, individuals with the most complex and intensive needs have the most limited range of housing options at all points on their continuum of symptom acuity.

There is a significant population of individuals whose complexity and intensity of needs involve interplay of mental health and physical/medical concerns that require long-term, and perhaps life-long, residential support in secure and specialized environments. An example of this level of service enhancement is represented in the proposal for a "Long Term Care Psychiatric Outreach Team" currently being reviewed by the Systems Table. Within the current constellations of community supports, the closest approximation of this service is the long-term care system. The current long-term care system has limited capacity in terms of staffing expertise in mental illness assessment and treatment, number of direct care staff available, and the ability to address issues relating to acting out behavior, interpersonal conflict and the resultant safety issues for the staff, individuals and co-residents.

Consultations with Homes for Special Care (HSC) personnel identified significant concerns regarding their capacity to identify appropriate community based residential beds for individuals with the most complex and intensive needs. These concerns are compounded by the overall lack of single-room accommodations in programs that have the capacity to provide specialized residential treatment. The domiciliary hostel system emerges as a primary source of available beds for HSC, despite the fact that it lacks the capacity to consistently provide single room accommodations and specialized in-house support. What is required is a mechanism that would provide access to a centralized database for accessing high support community living programs, and provide systematic forums for multi-stakeholder individualized treatment planning.

Accordingly, the Special Project for Systems Integration recommends:

RECOMMENDATION #3:
HOUSING RESOURCES AND CONSUMER CHOICE

That the Champlain Mental Health Network provide leadership in addressing the housing needs of individuals with severe and persistent mental illness on a systems wide basis by:

- ***Advocating for significant investments to increase the capacity of community-based residential supports to provide service to individuals with the most complex and acute needs.***
- ***Facilitating the development of a systems wide network to explore issues regarding residential support capacity, opportunities to increase collaboration and integration, and to inform overall residential systems enhancements. A high priority should be placed on enhancing residential services for individuals who are not adequately served by current residential supports.***
- ***Facilitating ongoing collaboration between Homes for Special Care and Ottawa Housing's domiciliary care program to identify potential high support homes/beds, and to facilitate access to Homes for Special Care supports and resources for individuals requiring this level of support.***
- ***Exploring the possibility of developing an integrated mechanism to facilitate multi-stakeholder residential case planning for hard to serve consumers.***
- ***Providing leadership in the development of service enhancements to increase the capacity of long term care settings to provide service to individuals with severe and persistent mental illness.***

The Domiciliary Hostel System

The City of Ottawa Housing Branch's domiciliary hostel program places a significant number of individuals with mental illness within the current system of community residential supports. The domiciliary hostel system is not specifically designed to care for individuals with intensive mental health, developmental, and/or physical/medical needs. However, due to current gaps in supportive and supported housing resources, the domiciliary hostel system is often the default option for the community placement of individuals with severe and persistent mental illness.

The Special Project for Systems Integration initiated extensive consultations with consumers, community stakeholders, domiciliary hostel operators, and City of Ottawa personnel to assess the capacity of the domiciliary hostel system to provide residential support to individuals with severe and persistent mental illness. The purpose of these consultations was two-fold: to describe gaps in service capacity and identify opportunities for collaborative initiatives to enhance overall service delivery; and to highlight limitations in service delivery and ways to support the development of enhanced residential services for individuals with the most complex needs.

Stakeholders reported concerns surrounding the application of group care for individuals with severe and persistent mental illness. This is particularly relevant to domiciliary care programs that tend to congregate individuals in one setting with shared communal spaces and have a limited capacity to provide single room accommodations. Consumers state that while they desire a certain level of privacy in their daily living, they also appreciate the opportunity for social engagement offered by group living. What is lacking in the domiciliary hostel system is a balance between these dynamics. The lack of access to private room accommodations a key concern. Individuals whose symptoms create impairments in interpersonal functioning face social pressures in domiciliary home environments that present significant challenges to their ongoing recovery process. Individuals whose stress and/or psychiatric symptoms manifest in acting out behaviour are at higher risk of harm to themselves and/or others in group settings. Having multiple individuals with complex needs in one environment further compounds this dynamic. However, as reported by operators, there are inherent issues, largely stemming from resource issues that limit the extent to which the current domiciliary care system can make environmental changes to address these concerns.

RECOMMENDATION #1:
DOMICILIARY HOSTEL SYSTEM

That the capacity of current residential supports to provide single room accommodations be a priority item for discussion and planning with regards to systems wide enhancements in residential services.

Domiciliary hostel operators reported that they have limited resources to recruit staff with extensive training and experience in mental health crisis intervention, or to facilitate training for existing staff. The general lack of program staff with expertise in the assessment and treatment of individuals with severe and persistent mental illness and complex needs has significant impact upon the level of treatment support residents receive in domiciliary hostel care. Program staff consult and collaborate with other professional services supporting residents, but their capacity to provide input into treatment plan development, and to facilitate on-site treatment interventions is often limited by their level of training and experience regarding serious and persistent mental illness. This lack of expertise is further compounded by the fact that the number of direct-care staff is limited at any given time, and that the responsibilities of these staff often include facilitating activities of daily living and operational responsibilities that are not primarily mental health related.

Some developments have emerged within the system to address the lack of training among program staff. These include: the Homes for Special Care's ongoing development of a home-owner's guide to working with individuals with serious and persistent mental illness; the Ottawa Supported Living Resource Network's ongoing work to develop forums for information sharing

and education for residential care providers; and information sharing and education initiatives that are embedded in the ongoing supports provided by intensive community support programs and psychiatric outreach teams.

RECOMMENDATION #2:
DOMICILIARY HOSTEL SYSTEM

That the Champlain Mental Health Network play a leadership role in initiating multi-stakeholder consultations to:

- ***Identify the training needs of domiciliary care staff and the systems issues that impact upon access to training.***
- ***Develop mechanisms to facilitate multi-stakeholder collaboration in the provision of training to residential staff that is accessible and sustainable.***
- ***Incorporate existing training initiatives in these developments.***

The lack of capacity of domiciliary hostel programs to provide adequate rehabilitative and skill building programming for residents is of concern to systems stakeholders. These limitations stem from inadequate resources to support the staffing and materials required to provide such programming. Although residents are often encouraged to play a role in the activities of daily living of the home, the time and attention staff have to devote to individualized skill building programming is limited. Further, safety issues and operational standards generally preclude residents from taking part in some activities. Kitchen areas, for instance, are often off limits to residents for safety reasons.

Similar concerns were expressed with regards to the provision of recreational/ occupational programming in the domiciliary hostel system. Again, housing operators do not receive enhanced funding to support the staff and materials required to provide extensive, individualized and structured therapeutic recreational activities. This is further compounded by the lack of ready access to such activities in the community. When activities are available, residents often have difficulty covering even nominal costs of attending. Transportation to and from community activities also presents a challenge. Many of the programs consulted seek to provide transportation for residents when possible, but dedicated resources are not available to facilitate this on a consistent basis. Moreover, domiciliary hostel operators have limited capacity to pursue the involvement of volunteers and/or student placements in their programming activities, although these resources have the potential to provide valuable support. Staffing pressures create challenges in establishing ongoing relationship with relevant educational programs and/or volunteer organizations and supervising placements in-house volunteer and/or student placements.

RECOMMENDATION #3:
DOMICILIARY HOSTEL SYSTEM

That the Champlain Mental Health Network provide leadership in:

- ***Advocating for enhanced resources for the provision of activity and skill building programming in domiciliary hostel programs, and in other residential and community based settings.***
- ***Facilitating planning between domiciliary care operators, other community-based residential support programs, Canadian Mental Health Association and Homes for Special Care personnel, and others stakeholders in the development of collaborative activity-based programming for individuals with severe and persistent mental illness, capitalizing on potential efficiencies that can be found by sharing resources, facilitating shared transportation, etc.***
- ***Supporting domiciliary hostel providers in developing a mechanism to facilitate access to volunteer and student support in the provision of in-house programming to individuals with complex needs.***

The findings of the Special Project for Systems Integration show that individuals with severe and persistent metal illness experience significant barriers to accessing appropriate and sustainable housing to support their process of community integration. Stigma and poverty, impairments in independent functioning, and limitations in social housing and other rental subsidy resources impact their access to independent housing options. Access to both supported and supportive housing, and particularly to rehabilitative housing, is limited by the impact of complex mental health needs upon individual functioning and the capacity to engage in rehabilitative programming. The system lacks the overall capacity to provide individuals with specialized and intensive residential support in secure community based treatment environments when they are at their most acute and symptomatic stages of their recovery process. The system also lacks the ability to support the recreational and vocational programming needs of these individuals. The domiciliary hostel system often becomes the default option for these individuals despite significant limitations in the capacity of that model of care to address their overall recovery needs.

As a result of these factors, the recovery journey for many individuals with severe and persistent mental illness is often marked by inappropriate and inadequate residential supports and the constant risk of residential placement breakdown. When placements fail, these individuals have limited alternatives, and they become at increased risk of rehospitalization as their condition deteriorates. These are not hallmarks of a person-centred, recovery oriented system of residential support.

CONCLUSION

The Special Project for Systems Integration conducted extensive consultations with professional stakeholders, consumers, and families to explore the systems issues that impact upon the community integration of individuals with severe and persistent mental illness in the Ottawa region. These investigations identified significant concerns with regards to the capacity of individuals with the most complex needs to access specialized and integrated services from across the continuum of inpatient and community based programming. Currently, specialized and intensive inpatient and community interventions are supporting many individuals with severe and persistent mental illness in their recovery journey. Where the current mental health system falls short is in the provision of these services to individuals during the most acute stages of their illness, when they are most impaired in their overall functioning, have the least insight into their illness, and are least able to engage in treatment planning and maintain treatment compliance. These service gaps exist in all domains of inpatient and community integration support. Of particular note are the service gaps in residential support and community integration. Individuals with severe and persistent mental illness face significant challenges in exercising choice in their housing. Supported independent housing is often beyond the means or capacity of many individuals. Community residential supports have a lack of capacity to support and provide treatment and programming for individuals with severe and persistent mental illness. These limitations are further exacerbated by the lack of consistency in collaboration and consultation between service providers, and particularly between inpatient and community settings. This lack of consistency frustrates effective transitional planning and a systems-wide continuum of care. In terms of person-centred planning, consumers and their family members have significant concerns with the extent to which they are engaged as active participants in treatment planning and implementation processes.

What results is an overall failure by the system to facilitate specialized, integrated, person-centred and recovery focused treatment for individuals with the most acute and complex needs. Inadequate resources are a primary impediment to service enhancement. Some initiatives could be taken within existing resources. The Special Project for Systems Integration has outlined several recommendations for concrete actions to support systems change and identified key stakeholders who are positioned to support these activities. Many of these recommendations, and the principles upon which they are based, are well established in international, national and provincial policy and evidence-based practice documents. Translating principles into practice will require strong leadership from across the continuum of the mental health system.

APPENDIX A

DATA GATHERING ACTIVITIES

IDENTIFICATION OF TARGET POPULATIONS

The Special Project for Systems Integration initiated a range of activities to develop a general profile of the target populations for the supports and services that it would be assessing. The primary focus of this information was on diagnostic and symptom factors, and their implications in terms of treatment and service needs, challenges to community placement, and risks of re-hospitalization. These activities included:

- Chart audits of a small sample of individuals who had been discharged from ROHCG inpatient units and who required re-admission within 90 days;
- Interviews with social work professional practice leads from the ROMHC and BMHC;
- Interviews with community based mental health and intensive support workers who support individuals discharged from inpatient services to community placements;
- Interviews with service coordination and brokerage personnel, and intensive treatment and support programs for individuals with intellectual disabilities and/or dual diagnosis;
- Participation in multi-stakeholder case conferences regarding community treatment and support planning for individuals with complex needs.

STAKEHOLDER CONSULTATIONS

Case management and community support stakeholders

Consultations were initiated with a range of professional stakeholders providing discharge planning, intensive case management and community support, and other community based services. The primary focus of these consultations was on issues relating to discharge and transitional planning processes, information exchange, service provision and integration, accessibility and general challenges in the community placement and support of individuals with serious and persistent mental illness. These consultations included:

- Interviews with the social work professional practice leads of the ROMHC and BMHC;
- Group presentation and discussion with social work staff of ROMHC and BMHC;

- Questionnaires distributed to social work staff of ROMHC and BMHC;
- Group presentation and discussion with community based mental health workers/case managers;
- Questionnaires distributed to community based mental health workers/case managers;
- Interviews with Ottawa based ACT team leaders/managers;
- Questionnaires distributed to Ottawa based ACT teams;
- Participation in multi-stakeholder case conferences regarding service planning for individuals with complex needs;
- Interviews with drop-in/centre based programs providing a range of services to individuals with mental illness;
- Interviews with Community Health Centres;
- Interview with the Community Care Access Centre;

Housing/Residential Stakeholders

Consultations were initiated with a range of stakeholders providing residential services and support to residential placements for individuals with serious and persistent mental illness. The primary focus of these consultations was on access criteria, service provision, and capacity to serve complex needs and overall issues in systems development. These consultations included:

- Structured interviews with a cross section of domiciliary hostel service providers involved with the City of Ottawa's Housing Branch/Supported Living Services domiciliary hostel program;
- Interviews with City of Ottawa Housing Branch and Supported Living Services program staff;
- Interviews with Homes for Special Care program staff;
- Participation in multi-stakeholder consultation meeting facilitated by the City of Ottawa's affordable housing program;
- Structured interviews with intensive support/rehabilitative housing programs;
- Interview with the Housing Loss Prevention Program;
- Interview with shelter system program staff;
- Participation in the initial session of the Housing Task Force of the Champlain Mental Health Network's Intensive Level Working Group;
- Interview with Community Care Access Centre staff regarding long term care service provision;
- Interview with Royal Ottawa Place personnel;

Consumers/Consumer Advocates

Consultations were initiated with consumers of inpatient and community based mental health services, personnel representing consumer initiated support programs, Patient Advocate/Patient Rights Advisors and the ROHCG Patient Representative. The focus of these consultations was on the nature and extent of communication and collaboration between consumers and service providers in treatment planning and the identification of key issues of importance for consumers with regards to wellness and recovery. These consultations included:

- Interviews with the ROMHC Client Empowerment Council;
- Interviews with Psychiatric Survivors Ottawa staff;
- A focus group targeting consumers of ROMHC interventions;
- A focus group targeting peer support workers involved in Psychiatric Survivors Ottawa's Wellness Project;
- Interviews with the Psychiatric Patient Advocate Office's Patient Advocate and Patient Rights Advisors overseeing ROHCG inpatient services;
- Interviews with the ROHCG Patient Representative.

Consultations with Families/Family Advocates:

Consultations were also initiated with family members of individuals with serious and persistent mental illness and with family advocates. The focus of these consultations was on the nature and extent of collaboration, communication and support extended to family members who are supporting individuals in inpatient and community based treatment, and in identifying their primary concerns regarding the capacity of the mental health system to provide adequate levels of support in both inpatient and community based settings. These consultations included:

- Meetings with the Family Advisory Work Group (FAWG) of the Champlain Mental Health Network;
- Questionnaires distributed to family members through the FAWG's mailing list.

DUAL DIAGNOSIS CONSULTATIONS

Consultations were initiated with individuals and programs involved in the development, brokerage, and provision of services to individuals with dual diagnosis. These scope of these consultations included developmental sector agencies funded by the Ministry of Community and Social Services and mental health agencies funded by the Ministry of Health and Long Term Care. The focus of these consultations was on the capacity of service providers to address the complex needs of individuals with dual diagnosis in both inpatient and community based settings and the extent to which collaboration and integration

exists between ministries in terms of service development and delivery. These consultations included:

- Interviews and participation in systems development meetings with the Eastern Region Network for Specialized Care;
- Participation in Developmental Services Ottawa (transfer payment agency Executive Directors planning committee) meetings;
- Structured interviews with developmental sector transfer payment agencies providing residential support and other service interventions;
- Interviews with developmental sector day program/outreach services personnel;
- Interviews with Service Coordination personnel;
- Interviews with Citizen Advocacy personnel;
- Interviews with personnel from the Dual Diagnosis Service of BMHC;
- Interviews with the ROHCG Dual Diagnosis Consultation and Outreach Team;
- Participation in the Dual Diagnosis Action Group meetings;
- Interviews with the CMHA Ottawa Dual Diagnosis Program;

APPENDIX B

INFORMATION GATHERING TOOLS

The Special Project for Systems Integration developed a number of tools to facilitate its information gathering activities. These include

I. Community-based support worker questionnaire
II. Community support program interview tool
III. Consumer focus group tool
IV. Consumer group interview tool
V. Developmental services residential caregiver interview tool
VI. Family group interview tool
VII. Family questionnaire
VIII. Residential caregiver interview tool
IX. Social work staff questionnaire
X. Transition planning chart audit tool
XI. Treatment and transitional planning tool

A sample of each tool follows.

APPENDIX B

I. COMMUNITY-BASED SUPPORT WORKER QUESTIONNAIRE

Community-Based Agency/Role: _____

1. Are community-based support workers involved in the ROHCG admissions process with regards to providing information regarding the client's mental status leading to admission, de-compensation issues and etc.? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

2. Do frontline/primary workers have access to inpatient staff for ongoing consultation regarding treatment plan development and implementation, community re-integration challenges, target discharge dates and etc.? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

3. Is there a written treatment plan that outlines client, family, inpatient staff and community-based support workers' (ACT, family physician, community psychiatrist, counselor, housing provider etc.) roles and responsibilities in treatment implementation? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

4. Are the community-based support workers involved in identifying and presenting community re-integration planning options in the discharge planning stage? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

5. Does discharge planning address the following issues:

- Housing

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Drug card, medication compliance

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Financial issues (Ontario Works, Ontario Disability Support Program, Canada Pension Plan Disability, and other pensions)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Capacity issues – Public Guardian & Trustee, Substitute decision maker, Community treatment order.

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Vocational issues

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Identification— birth certificate, SIN, health card, immigration

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- ADL needs (i.e. home support, personal care needs, etc.)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

6. Do in patient staff provide follow-up support after the patient is discharged? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

7. Are early intervention plans and crisis intervention plans discussed and developed?

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

8. Please identify 3 high-priority issues that impact negatively on the potential for successful community re-integration of ROHCG inpatients:

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____
_____

APPENDIX B

II. COMMUNITY SUPPORT PROGRAM INTERVIEW TOOL

AGENCY: DATE OF INTERVIEW:

ADDRESS/PHONE:

STAFF INTERVIEWED (NAME/ROLE):

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1. Overview of range of services provided

2. Staffing: background and education

3. Referral process and criteria for eligibility
   - Criteria for access;
   - Referral process;
   - Supports required to access programs

4. Capacity to serve special needs re:
   - Serious and persistent mental illness
   - Concurrent disorders/dual diagnosis;
   - Behavioural issues;
   - Physical disabilities;
   - Communication disorders

5. Stats:
   - # Referrals refused re. special needs exceeding capacity;
   - # placement breakdown re. extensive special needs

6. Systems issues/gaps and barriers identified

APPENDIX B

III. CONSUMER FOCUS GROUP TOOL

1. In your experience as an inpatient with the ROHCG, how informed and involved did you feel in terms of:

    i. ***Patients Rights*** information:
    - Did anyone speak to you about this? If so, who?
    - If info was given, when and how was information shared?
    - Are there better ways for this information to be shared?

    ii. ***Diagnosis and Treatment*** information:
    - Did anyone explain why you were admitted and what would be done to try to help you?
    - Did you feel you had any input in the treatment you received?
    - Was your treatment plan meaningful to you? Did you feel that the treatment you received actually helped you in your recovery and wellness?
    - Of all the staff you had contact with while you were an inpatient, who do you think was the most supportive to you?
    - Any other comments/concerns?

2. While you were receiving inpatient care, were you able to maintain connections and support from the ***support networks*** that helped you in the community, in terms of:

    i. ***Professionals*** who supported you:
    - ACT teams
    - Doctors/psychiatrists
    - Care providers
    - Others

    ii. Your ***personal supports***:
    - Family members
    - Friends
    - Others

3. When you think about your experience of leaving hospital and ***returning to the community***:
    - On the day you were discharged, what was the most important concern for you, or what did you feel you needed the most? Were you helped with this?
    - As you left the hospital, did anyone help you develop a plan to get through difficult times?
    - While you are in the community, what is the most important thing, or things, that help you stay out of hospital?

4. Have you had any experiences getting help from community hospitals (emergency wards) other than the ROH at times of crisis? What was helpful and what was not?

5. Is there anything that we haven't asked about that you feel is important for us to know, in terms of your experience receiving treatment from the ROHCG?

APPENDIX B

IV. CONSUMER GROUP INTERVIEW TOOL

Note: this tool is intended as a guide for interviews with patient/consumer advocacy groups, with a focus on generalized transitional planning systems issues. It is not intended for interviews with individual consumers regarding their specific transitional planning processes.

Consumer Group/Advocate: _____

Date of Interview: _____

---

1. When consumers are referred to ROHCG inpatient care, are they properly informed (i.e. what information is provided, who provides it, is it adequate) re:

    i. The admissions process
    ii. Treatment model of admitting service
    iii. Anticipated length of stay, issues that impact on community reintegration

2. Do consumers feel that they are appropriately involved in and/or informed of the decision to be admitted to ROHCG inpatient care?

3. Is information provided to consumers regarding the nature of their mental illness, treatment options, and the methods of the treatment program they have been admitted to? Are consumers involved, in a meaningful way, in the treatment and transition planning processes? Are meaningful choices provided?

4. Do treatment plans address issues that consumers feel are important in terms of their ability to return to the community (i.e. symptomatology, medication, activities of daily living, housing issues, vocational/recreational skills, etc.)?

5. Is transition planning part of the initial treatment planning process (i.e. anticipated discharge dates, needs areas to be addressed, etc.)?

6. Are key elements of treatment plans followed through in the course of treatment? Are there issues that are important to consumers that are not addressed in treatment?

7. Do consumers have concerns regarding the role of family members in the admissions, treatment and transition planning processes? Is the input of family members and other personal supports pursued to the extent that the consumers want it to be?

8. When consumers have community-based professional supports in place (ACT, case management, residential caregivers, etc.), are they brought into the admissions, treatment planning and transition planning processes to the extent that the consumers want them to be?

9. Are consumers' physicians involved in the admissions, treatment and transition planning processes to the extent they want them to be?

10. Do treatment and transition plans involve a written component that outlines the responsibilities of all the individuals involved?

11. To what extent are housing needs addressed in transitional planning? Do consumers feel that a meaningful choice is provided?

12. Do transition plans address issues that consumers feel are important in terms of their ability to return to the community, including:

    i. Activities of daily living skills building/supports
    ii. Vocational/rec. needs
    iii. Transportation needs re. rec./voc./medical appointments, etc.
    iv. Medication, drug cards
    v. Financial issues (Ontario Disability Support Program, Ontario Works, etc.)
    vi. Personal documents: health card, SIN card, birth cert., etc.

13. Do transition plans identify crisis prevention and intervention measures, with clearly identified roles of key individuals?

14. To what extent does community reintegration happen in a gradual way, with opportunities to visit housing and community supports prior to transition?

15. To what extent are ROHCG staff involved in supporting consumers after community re-integration has occurred? Is this level of support appropriate?

16. Other issues and/or recommendations?

APPENDIX B

V. DEVELOPMENTAL SERVICES RESIDENTIAL CAREGIVER INTERVIEW TOOL

AGENCY: **DATE OF INTERVIEW:**

ADDRESS/PHONE:

STAFF INTERVIEWED (NAME/ROLE):

---

1. RESIDENCE QUESTIONS:

- Number of homes
- Average # residents per home
- Shared or single rooms
- Crisis/respite beds

2. AGENCY REFERRAL QUESTIONS:

- Access criteria
- Orientation process -- visits, day stays, overnight stays
- Per diem rates/system

3. STAFFING:

- Composition re: ratios, staffing backgrounds/years of experience and professional designations:
- Specialized staffing re: occupational therapy, vocational, recreational, behavioural therapy, dietary, etc.
- Training opportunities/issues re. staffing and resources.

4. **SPECIAL NEEDS POPULATIONS:**

- Capacity re: dual diagnosis, physical/sexual behaviours, physical disabilities, communication disorders, etc.
- Special needs designated beds/homes
- Anticipated service enhancements/developments re. special needs capacity
- Crisis response protocols
- Stats for past year re:
    - Referrals refused for lack of capacity
    - Placement breakdowns due to special needs exceeding capacity
    - Crises requiring emergency department interventions

5. ACTIVITIES & PROGRAMMING:

- In-house programming re:
    - Activities of daily living skill building
    - Vocational
    - Recreational

- Accessibility of community-based programming
- Barriers to accessing community programming (availability, transportation, etc.).

6. MEDICAL/DENTAL:

- How are medications dispensed in homes
- Issues re. access to family doctors, dentists, psychiatric support, community health centres, and other specialized primary health services
- # Referrals that do not have designated doctor/dentist

7. CONSENT AND CAPACITY:

- Process for substitute decision makers, public guardian and trustees regarding treatment decisions and financial matters.
- Overall level of family/substitute decision maker/public guardian & trustee involvement

8. SYSTEMS ISSUES:

- Significant systems issues that impact on capacity to provide support to special needs populations
- Other systems issues

APPENDIX B

VI. FAMILY GROUP INTERVIEW TOOL

Note: this tool is intended as a guide for interviews with consumer family advocacy groups, with a focus on generalized transitional planning systems issues. It is not intended for interviews with individual consumers regarding their specific transitional planning processes.

Family Group: _____

Date of Interview: _____

---

1. To what extent are family members involved in the ROHCG admissions process, with regards to:

    i. Issues of confidentiality and/or other barriers
    ii. Providing historical information regarding the patient's psychiatric condition, strengths and needs, support systems and etc.
    iii. Receiving information regarding the reason for and terms of admission
    iv. Receiving information regarding patient rights/patient advocate

2. To what extent are family members provided general information regarding institutional operations (telephone contacts, visiting hours, privilege levels, parking , etc.)

3. Are family members given a key contact person to address ongoing concerns regarding treatment and/or any other issues with respect to the patient's care? Do family members have appropriate access to treatment staff (i.e. psychiatrists, nursing staff, etc.) to address concerns and/or field questions?

4. To what extent do family members receive information regarding the patient's initial diagnosis, treatment options and the treatment planning process?

5. Do family members receive information regarding supports that are available to them, either through the ROHCG or community based?

6. To what extent are family members involved in the early treatment and transition planning processes? Are there barriers to their involvement? If family members are involved in the treatment and transition planning processes, how does this take place (what type of consultation, who is present, what role does family asked to play, etc.)?

7. To what extent are family members involved in supporting the ongoing treatment process?

8. Do treatment and transition plans involve a written component that outlines the responsibilities of all the individuals involved?

9. To what extent is family members' contact with the patient facilitated and supported by inpatient staff?

10. What are the primary concerns that families have with regards to community re-integration? To what extent does treatment and transition planning address these issues?

11. To what extent do families play a role in supporting community re-integration?

12. From the family's perspective, to what extent are community resources activated to support re-integration? Are these supports adequate?

13. Is contact between family members and community supports facilitated? If so, what is the nature of this contact?

14. To what extent are housing needs addressed in transition planning? Do families feel that meaningful choice is provided?

15. Do transition plans identify crisis prevention and intervention measures, with clearly identified roles of key individuals?

16. To what extent does community reintegration happen in a gradual way, with opportunities to visit housing and community supports prior to transition? Are families involved in supporting this process?

17. To what extent are ROHCG staff involved in supporting the patient and their family supports after community re-integration has occurred? Is this level of support appropriate?

18. Other issues and/or recommendations?

APPENDIX B

VII. FAMILY QUESTIONNAIRE

(Please note: if you require more space for comments than is provided, please feel free to use separate sheets of paper).

1. Please identify the ROHCG program(s) that your family/family member has been involved with:

2. In your family's experience, does the individual being admitted to ROHCG inpatient care provide consent for the sharing of information with family members? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

3. When an individual is being admitted to ROHCG inpatient care, are family members asked to provide information about the individuals' psychiatric history and presenting condition/concerns? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was the individual agreeable to you providing this information: ___Yes ___ No

Comments:

4. Are family members given information regarding the patient's initial diagnosis, terms of admission and treatment options? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

5. Are family members given general information regarding ROHCG institutional operations (visiting hours and phone contact, patient privilege levels, parking, etc.). (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

6. Are family members given information regarding supports that are available to them, either through the ROHCG or community based? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

7. Are family members given a key ROHCG contact person to address ongoing concerns regarding treatment and/or any other issues with respect to the patient's care? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

8. While the individual is in treatment, do family members have access to treatment staff (i.e. psychiatrists, nursing staff, etc.) to address concerns and/or field questions? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

9. Are family members involved in treatment planning? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Please add comments regarding how family members' involvement is supported/not supported:

10. Does the treatment plan identify the supports family members can provide to the treatment process? (Please circle one);

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

11. Do family members receive a written treatment plan that identifies key individuals involved in treatment and their roles/commitments? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

12. Are individuals with identified roles in the treatment process held accountable for following through on their commitments? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

13. Is contact between family members and the patient facilitated and supported by inpatient staff? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

14. Please identify issues that you feel are most important to consider when planning for re-integration of an inpatient to the community.

15. Are these issues addressed in transition/discharge planning? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

16. Are families asked to play a role in supporting community re-integration? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

17. From the family's perspective, are adequate community resources available to support re-integration? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

18. From the family's perspective, to what extent are community resources that are available included in the re-integration plan? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

19. Is contact between family members and community supports facilitated? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for this contact granted by the patient: ___Yes ___No

Comments:

20. Are meaningful choices for housing available to patients planning for community re-integration? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

21. Are housing needs addressed in discharge/transition planning? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

22. Does community reintegration happen in a gradual way, with opportunities to visit housing and community supports prior to transition? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

23. For patients returning to the community, do discharge/transition plans identify crisis prevention and intervention measures? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

24. Are post-discharge crisis prevention and intervention options adequate? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

25. ROHCG patients who have been discharged often access community hospital emergency services in times of crisis. From the family members' perspective, are the interventions provided in these settings adequate? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

26. Are ROHCG staff involved in supporting the patient and their family supports after community re-integration has occurred? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

27. Are there any other issues or concerns that you would like to note?

Thank you for taking the time to complete this questionnaire!

APPENDIX B

VIII. RESIDENTIAL CAREGIVER INTERVIEW TOOL

AGENCY: **DATE OF INTERVIEW:**

ADDRESS/PHONE:

STAFF INTERVIEWED (NAME/ROLE):

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1. RESIDENCE QUESTIONS:

How many residents?
Number of single rooms
Number of people sharing
Weekends out vacation/absence policy for retention of bed

2. AGENCY REFERRAL QUESTIONS:

Who are you able to provide support to?
Referral process?
Orientation Process –visits, day stays, overnight stays, 2-3 days, weekend stays?
Waiting list?

3. STAFF COMPOSITION: RATIOS, STAFFING BACKGROUNDS/YEARS OF EXPERIENCE AND PROFESSIONAL DESIGNATIONS:

Does staff composition include: nurses, social workers, occupational therapy, recreational therapy, behaviouralists, counseling, developmental specialists, addiction counselors, anger management specialists, mental health counselors, dieticians, physicians, psychiatrists, psychologists, primary key contact for discharge/transition?

Number of support hours?
Variance of hours of support (After hours, overnight, evenings, weekends, holidays)?

Staff ratio during the day
Staff ratio during the evening
Staff ratio overnight
Staff ratio weekends/holidays
Staff composition during these shifts

4. SKILLS & EXPERTISE DISCIPLINES: OPPORTUNITIES FOR STAFF DEVELOPMENT AND SKILLS DEVELOPMENT?

Opportunities/expectations regarding training in: nursing, counseling: suicidal ideation and attempts, self harm behaviour (cutting, burning), addiction, eating disorders, developmental, behavioural, anger management, assertiveness, sexual behaviour counseling, sexual assault counseling, suicide intervention skills, crisis intervention skills, symptomatology awareness, nutrition, exercises, recreology and leisure, occupational and employment, pastoral care, foot care, literacy etc.?

5. FAMILY INVOLVEMENT:

Sharing of information, education, advising of current status situations, role of the substitute decision maker?

6. SAFETY:

Crisis intervention skills, early intervention plans, suicide intervention training and responses to suicidal ideation and attempts, self harm behaviour. Posted rules regarding verbal and physical aggression, medication compliance issues, smoking issues (allowed, rationed amount, special rooms), dealing with wandering behaviour?

7. DISABILITIES/SPECIAL NEEDS:

Accessibility issues (stairs, elevators, room for wheel chairs and walkers). Ability to support vision, hearing, mobility, incontinence, wheelchair transferring, personal care (bathing, toileting, dressing, feeding) sexual behaviour (flashing, undressing, masturbating), aggressive behaviour (verbal and physical), addiction issues (drugs, alcohol, prescription drugs), eating disorders. How are these people assisted?

Level of support able to provide (i.e., accompaniment, monitoring, counselling, treatment, short/long term support)?

8. MEDICATIONS:

Meds dispensing regime, who and when, what happens if one refuses meds? How many times before the doctor is notified? What is done to motivate meds compliance? How are people taught to have control over their meds, their own meds taking, etc?

9. ACTIVITIES & PROGRAMMING: STRUCTURE DURING THE DAY

Besides meals and sleep times, programming regarding individual activities, self-care activities, room care activities, meal preparation, laundry, shopping, personal health care, communication skills, interpersonal relationships, anger management, exercising, meds taking, money management, leisure activities (i.e. reading, knitting, sewing etc.?

Other programs and staff expertise that can be accessed (i.e. activities of daily living assessments, life skills training, day programs, volunteer/employment support)

10. SOCIAL/GROUP ACTIVITIES

Outings, trips, camping, museums, shopping, movies, day programs, arts & crafts, bingos, cards, music, peer support and mentoring, volunteering?

11. FINANCIAL:

Daily, weekly, bi-weekly, monthly allowances? Public guardian and trustee applications, assistance with applying for needed pensions, assist with income taxes, securing a bank account*?*

12. TRANSPORTATION:

Accompaniment to appointments and activities, arrange for volunteer drivers, para transpo, bus tickets, taxis, arrange for bus passes, teaching bus taking?

13. OTHER ISSUES RELEVANT TO PLACEMENTS:

Reciprocal information exchange, ability to assist with short term stabilization issues i.e. acute care admissions, respite care, long term care placements, other supportive living arrangements?

14. SYSTEMS ISSUES IDENTIFIED:

APPENDIX B

IX. SOCIAL WORK STAFF QUESTIONNAIRE

Inpatient Unit/Program: _____

1. What is the range of roles assumed by social work staff on the treatment team (for example, individual/group counseling, family counseling, discharge planning, and etc.)?

2. At what stage in the inpatient treatment process does discharge planning begin?

3. To what extent are social workers able to facilitate the involvement of the individual's support network (family, residential care providers, community supports such as Case Management and ACT, etc.) in the treatment and discharge planning process? Are there barriers to this involvement? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

4. To what extent does the discharge process occur in a gradual manner, with opportunities for day/overnight visits to community placements prior to discharge? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

5. Are social workers able to provide short-term transitional support to individuals following discharge? If so, how does this take place? If not, what are the primary barriers to this role? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

6. To what extent are early intervention plans and crisis intervention plans incorporated in the discharge planning process? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

7. What issues regarding inpatient symptomatology and special needs present the most challenges to discharge planning related to securing residential placements and community support services?

8. To what extent is inpatient treatment able to address the concerns identified above, with regards to preparing the individual for discharge? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

9. To what extent are social workers able to access community-based resources to support discharge planning, with regards to:

- Housing

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Access to family doctor/dentist

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Financial issues (Ontario Works, Ontario Disability Support Program, Canada Pension Plan Disability, and other pensions)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Vocational programming

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Recreational/social activity programming

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Activities of daily living needs (i.e. home support, physical/personal care needs, etc.)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Community based professional supports (case management, ACT, counseling, etc.)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Other:

10. Please identify 3 high-priority issues that impact negatively on the potential for successful community re-integration of ROHCG inpatients:

1. _____

_____

2. _____

_____

3. _____

_____

_____

APPENDIX B

X. TRANSITION PLANNING CHART AUDIT TOOL

Patient: _____ **D.O.B.:** _____ **Gender:** M___ F___

Admission/Discharge history:

DIAGNOSIS/PRESENTING CONCERNS: (Identify by admission/discharge period)

TRANSITION RISK FACTORS SCREEN:

	At current admission	Previous discharge	Previous admission
1. Requires arrangement of residential placement different from that at admission.			
2. Requires financial discharge planning.			
3. Difficulty in impulse control (physical/verbally aggressive, suicidal, fire setting).			
4. History of serious and prolonged impairment in performance at work, school, or in activities of daily living.			
5. Has previously left this or other facility against medical advice.			
6. Numerous and/or lengthy past psychiatric hospitalization.			
7. Non-voluntary legal status.			

8. Serious medical condition or physical disability.

9. Substance abuse issues.

10. Member of family where there has been recent actual or suspected physical abuse.

11. Patient or family is in process of separation or divorce.

12. Diagnosed with mild or greater mental retardation.

13. Suspected organic mental disorder.

14. Has no involved or available family/significant other (including patients who refuse to permit family involvement).

15. Patient/family has history of non-adherence to discharge plans (including non-compliance with medication).

16. Patient's immediate family has another member with serious, current mental or medical illness.

17. Last discharge against medical advice.

APPENDIX B

XII. TREATMENT AND TRASITIONAL PLANNING

1. Multi-disciplinary inpatient team members involvement in assessment/treatment/ transition planning (extent to which plan addresses bio-psycho-social spectrum)?

2. Patient receiving services from ACT at point of admission? If so, ACT involved in initial assessment (information gathering) and treatment/transition plan development (roles/responsibilities in ongoing treatment)?

3. Patient and/or family provided info./education/support regarding mental health system, nature of patient's condition and course of treatment, responsibilities of key players in process, and key contacts/sources of information and support?

4. Patient and/or family/significant supports involved in initial assessment (information gathering) and treatment/transition plan development (roles/responsibilities in ongoing treatment)? Patient has opportunity for meaningful input and provided meaningful choices? Patient/family have identified roles/responsibilities in transitional process?

5. Community based supports/practitioners previously involved with patient (family physician, caregivers, community support agencies etc.) involved in initial assessment (information gathering) and treatment/transition plan development (roles/responsibilities in ongoing treatment)? To what extent does transition plans identify:
    i. roles/responsibilities in transitional support
    ii. mechanisms for timely information sharing
    iii. identification of key contact persons for all parties involved

6. Transition risk factors addressed in treatment plan?

7. Treatment and transition plan incorporates elements of psycho-social-rehabilitation?

8. Elements of inpatient treatment plan and other pre-existing intervention plans carried forward in transition plan?

9. Treatment plan includes anticipated date/time frame of transition, and patient, family, community supports informed?

10. Transition plan identifies relapse prevention measures, early warning signs of de-compensation and appropriate interventions and responsibilities of all parties. Also includes parameters/criteria for readmission if necessary, and key roles of all players?

11. Transition plans addresses any issues of cultural sensitivity?

12. Final plan written as contract between all stakeholders and patient, signed by all relevant parties?

13. Transition occurs gradually, with opportunities for patient/family to tour/meet with community care and support providers prior to actual engagement?

14. Transition involves follow up support from hospital staff in early stage of transition?

15. At discharge, patient referred for ACT supportive interventions?

16. Patient engaged with mental health service peer/consumer advocacy and support?

17. Plan assures necessary medications available in early stage of transition to community. Medications prescribed covered under provincial drug formulary?

18. Current status report re. discharge planning, barriers to community placement and etc.?

19. Other?

(This tool was adapted from Christ *et al.*, 1994).

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