Taking the Next Step: Designing Effective Transitional Supports for Community Reintegration of Forensic patients

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Rob Adams
Mark Rice

Background and Context

Ontario Shores

Inpatient Beds:

75 inpatient Forensic General beds – 3 clinical units of 25 beds each

Outpatient Services:

Forensic specific outpatient inter-professional team – currently supports 130 Forensic clients in the community

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Durham Mental Health Services

Ontario Shores
Centre for Mental Health Sciences

Background and Context

Ontario Shores

Dedicated funding for Transitional Housing and Case Management Supports

Customized approach to service delivery to meet the needs of specialized populations

Focus within Durham Region

Background and Context

<u>Durham Mental Health Services</u>

Community mental health service provider operating for almost 30 years

Some services (e.g., community support) focus on Whitby, Ajax and Pickering but we have many Region-wide services also, including Crisis Response, Mental Health Court Support and Family Support

Background and Context

Durham Mental Health Services

A major organizational strength is the quality and range of our partnerships with other local health and human services

In addition, our client-centered approach to care means that we adapt our services to client needs

In addition to specialized Forensics housing, we also partner with Ontario Shores on housing for Alternative Level of Care (ALC) clients

Condition Level System

Fully integrated privilege level system contained within each patients electronic health record

Patients obtain increasing amounts of time utilizing off ward privileges

Based on risk management and individual rehabilitation and recovery goals

Assessed by the clinical team and approved by the Administrative Director

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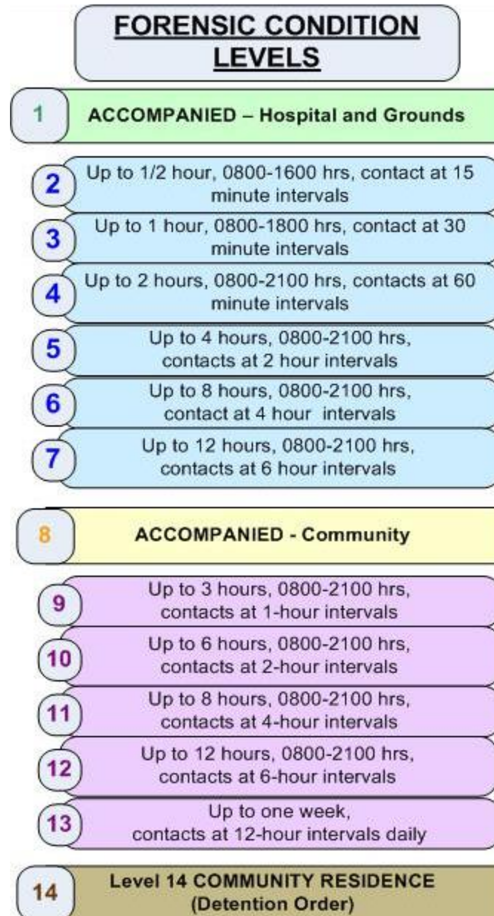
Condition Levels



- Principle: The intended whereabouts of the patient must be known at all times and must be in accordance with the conditions approved by the Administrative Director based on the patient's most current Ontario Review Board Disposition
- Condition levels are dependent on the patient's mental status. Levels of indirectly supervised conditions are attained sequentially and the expectation is that patients will move up one level at a time. Exceptions will be considered if a rationale is provided.

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Discharge Planning Process

Inpatient Social Worker is the "Discharge Co-ordinator"

D/C planning has a regional focus with linkage to the Forensic Programs in other regions – Forensics is a Provincial Program

Community Living condition must be in the disposition for d/c **but** discharge planning activities can begin prior

Discharge must be approved by the Administrative Director

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Transitional Case Management

Ontario Shores partnership with Durham Mental Health Services (DMHS)

Provision of 3 (DMHS) Forensic Transitional Case Managers assigned exclusively to forensic inpatients who are close to d/c

Integration with the inpatient clinical team (courtesy status at Ontario Shores)

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Transitional Case Management

Extension of the inpatient clinical team with a focus on community based activities

May "re-engage" if patient is re-admitted

Length of involvement is driven by goal attainment and clinical needs of the patient (average of 3 month post d/c from hospital)

Transitional Forensic Housing

Ontario Shores and Canadian Mental Health Association (CMHA)

- 8 individual beds in the community (apartment style)
- Dedicated case management support – both transitional and longer term
- Average LOS is 18 months
- Specific process for transition out of the bed to longer term housing

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Transitional Forensic Housing

Ontario Shores and Durham Mental Health Services (DMHS)

- 4 residential beds within one home
- 24 hour on site staff support
- Dedicated Case Management support – both transitional and longer term
- Average LOS is 15 months
- Flow through processes established to longer term housing options

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Key Success Factors

Early identification and engagement by the transitional case manager

Key linkage between inpatient and outpatient services – a “familiar face” for the patient

Specific criteria established for the transitional beds:

- Long stay patients
- Previous failed community reintegration
- Index offences that have created barriers to d/c placement

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Key Success Factors

Shared accountability (annual supplements mandated by MOHLTC)

Forum for on-going discussions about emerging issues and opportunity for resolution

Continuity of care – dedicated front-line clinicians from Ontario Shores and residential staff from DMHS

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Supporting Processes

- Routinized conferencing and Rapid Rounds
- Creation of “Forensic Discharge Coordination Committee” to:
  - Ensure seamless transition from inpatient to outpatient services
  - Case resolution planning for specific cases with community service providers
  - Engagement with specialized services (DDS/Geriatrics) to assist in d/c planning
  - Ensure that re-admission process is effective and minimize unnecessary hospital bed days

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A Patient's Perspective

Questions

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