

**Canadian Mental
Health Association,
Kenora Branch**

**LOCUS STEERING COMMITTEE
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Canadian Mental
Health Association
Mental health for all

Association canadienne
pour la santé mentale
La santé mentale pour tous

- The LOCUS Steering Committee was formed in 2015 to facilitate discussion on appropriate level of service provided to clients in two agencies and four programs.
- CMHAK- District Assertive Community Treatment Team and Forensic Case Management.
- Kenora Association for Community Living- Dual Diagnosis Program and Community Mental Health Support Services.



Assertive Community Treatment Team

The ACTT model is based on a recovery-oriented, long-term community based intensive case management service with specific eligibility and admission.

Criteria for admission: Client is aged 18 years or over; Axis I Diagnoses (Bipolar Disorder, Schizophrenia, or Schizoaffective disorder); Client is willing to participate in the frequency and intensity of ACTT services; Heavy system use (hospital admissions- more than 50 days in the past 2 years)

ACTT provides highly individualized client-centered treatment, rehabilitation, and support to individuals living with severe and persistent mental illness



Assertive Community Treatment Team

ACT Team is multi-disciplinary including a psychiatrist, nurses, social worker, concurrent disorder specialist, peer support worker, vocational rehabilitation worker and occupational therapist.

Provides highly individualized client-centered treatment, rehabilitation, and support to individuals living with severe and persistent mental illness

Provides assistance in areas such as:

- Medication education & support
- Psycho-social rehabilitation
- Activities of daily living
- Relationships
- Vocational rehabilitation
- Addictions
- Advocacy
- Family support



Forensic Case Management

Forensic Case Management is attached to the Mental Health Diversion/Court Support Program

Provides a strategic approach to supporting individuals with complex, high needs in a community setting while their matters are before the courts, or while they await admission to other community programs

Clients need to be referred through the Mental Health Diversion/Court Support Program



Forensic Case Management

Communicates with Kenora District Jail Nurses and Court Diversion worker re: medication pick up and plan for monitoring.

Meets and supports client from jail or court with undertaking and release plan. Support to residence or place of stay.

At intake, meets client at office or home and explains role of Court Program and expectations.

Collects collateral with Court Diversion Worker and sets up any assessments needed (Forensic-NCR; Fit to Stand; Risk, etc.; FASD; BISNO; DSO; Addictions and Mental Health Counselling; Application to Residential Treatment) Supports client with reminders and transportation.



Forensic Case Management

Daily monitoring of conditions- work out or report any breach; liaison with family if appropriate. Liaison with Recovery Home situations; Liaison with Lawyer- Crown and Court through Court Diversion worker.

Supports client with money management if appropriate; Hygiene and laundry (ADLs).

Once assessments are completed, support with referral to appropriate agency support services.

Discharge from Program once court matters are completed with referral transfer to new support agency when appropriate.



Intensive Case Management (CMHSS)

Intensive Case Management offers flexible, individualized, ongoing support that varies in intensity, which is based on consumer choice, and focuses on an individual's strengths, talents, and abilities. We encourage people to become involved in activities that develop supportive relationships, which establish valued roles through participation in our community.



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Kenora Association for Community Living
A Meaningful and Satisfying Life

Intensive Case Management

The priority population for intensive case management services is people aged 18 and over, who have a serious mental illness.

Participation is voluntary.

Once a person has been accepted into the program, the individual meets with a Community Consultant to jointly develop a support plan that assists persons to realize his or her personal recovery goals.



Intensive Case Management

Support services are flexible, based in the community, and tailored to the expressed needs of the individuals we serve.

Levels of support vary greatly from person to person.

Our services are available 7 days a week. Daily hours can vary based on individual needs, crisis, or emergent situations.



Intensive Case Management

Intensive Case Management Services offers a wide range of support options to people, in an effort to assist people in any foreseeable way. We assist people in finding and maintaining affordable housing.

Community Consultants assist people to manage their finances, which includes budgeting and personal banking strategies, in addition to accessing available funding.



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Intensive Case Management

Intensive Case Management Services offer assistance in time management skills to support people with making and keeping appointments, being on time for work or for social obligations, and with providing reminders for maintaining a medication schedule, as prescribed by a physician. We assist people in finding and securing competitive and/or meaningful employment.



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Intensive Case Management

Intensive Case Management Services encourage people to pursue their interests and to engage in recreational activities. We strongly advocate on behalf of the people we support. Funding for Intensive Case Management Services has been provided by the North West Local Health Integration Network (LHIN).



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Kenora Association for Community Living
A Meaningful and Satisfying Life

Intensive Case Management:
A flexible, individualized and ongoing support service dedicated to supporting individuals living with a serious mental illness. Based on consumer choice and focused on individual strengths, this service encourages activity, relationships, and participation in the community



Dual Diagnosis Program

Community Mental Health Support Services (CMHSS) provides Dual Diagnosis Services to adults and their families in the community of Kenora and in the Kenora/Rainy River District.

A dual diagnosis refers to the co-existence of an intellectual disability a mental illness

Services are provided based on the following principles: Persons-centred planning that is the least restrictive and the least intrusive for an individual; access to services as close to home as possible, with coordinated and effective linkages to community partners.

Dual Diagnosis Program

Dual Diagnosis Services include: access to specialists via videoconferencing and in-person consultation; support for families and front line staff; advocacy for individuals and their families to receive needed services; psychological education for individuals, families, caregivers, and service providers; development of strategies to effectively support individuals in the community; and support for accessing resources to improve quality of life.

Funding has been provided by the North West Local Health Integration Network (LHIN)



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District Peer Support Program, CMHAFF

Drop in can occur anytime.
One on One Peer Support
Outreach Program.
Family Worker
Forensic Peer Support.
Hearing Voices Workshop
Trained individuals in WRAP: Wellness
Recovery
Action Plan
Tammy Project- focus on providing
education to
the schools.
Serves individuals 18 years of age and
older.
Program looks at complementing services
that
are being offered.



Level of Care Utilization System

Using the LOCUS, level of care is determined by 6 Levels:

Level 1: Recovery Maintenance
and Health Management

Level 2: Low Intensity Community
Based Services

Level 3: High Intensity Community
Based Services



Level of Care Utilization System

Level 4: Medically Monitored
Non-Residential Services

Level 5: Medically Monitored
Residential Services

Level 6: Medically Managed
Residential Services



Level of Care Utilization System

In terms of identifying which agency is most appropriate to provide services to clients, we identified the following:

Level 1: Care can be managed by the client's family physician.

Level 2: Client can be managed by Peer Support.

Level 3: Clients can be managed by Community Mental Health Support Services



Level of Care Utilization System

Level 4: Care can be managed by the Assertive Community Treatment Team.

Level 5: Client can be managed within a step down service that is medically monitored.

Level 6: Clients require an inpatient admission to a Schedule 1 Facility.



Level of Care Utilization System

Representatives from each of the 4 programs met approximately every month to discuss their clients' LOCUS scores.

Based on the LOCUS scores, discussion was had to identify if clients could transition to other service providers and we were able to streamline and improve our services.

The committee recorded all of the clients who scored a Level 5



Level of Care Utilization System

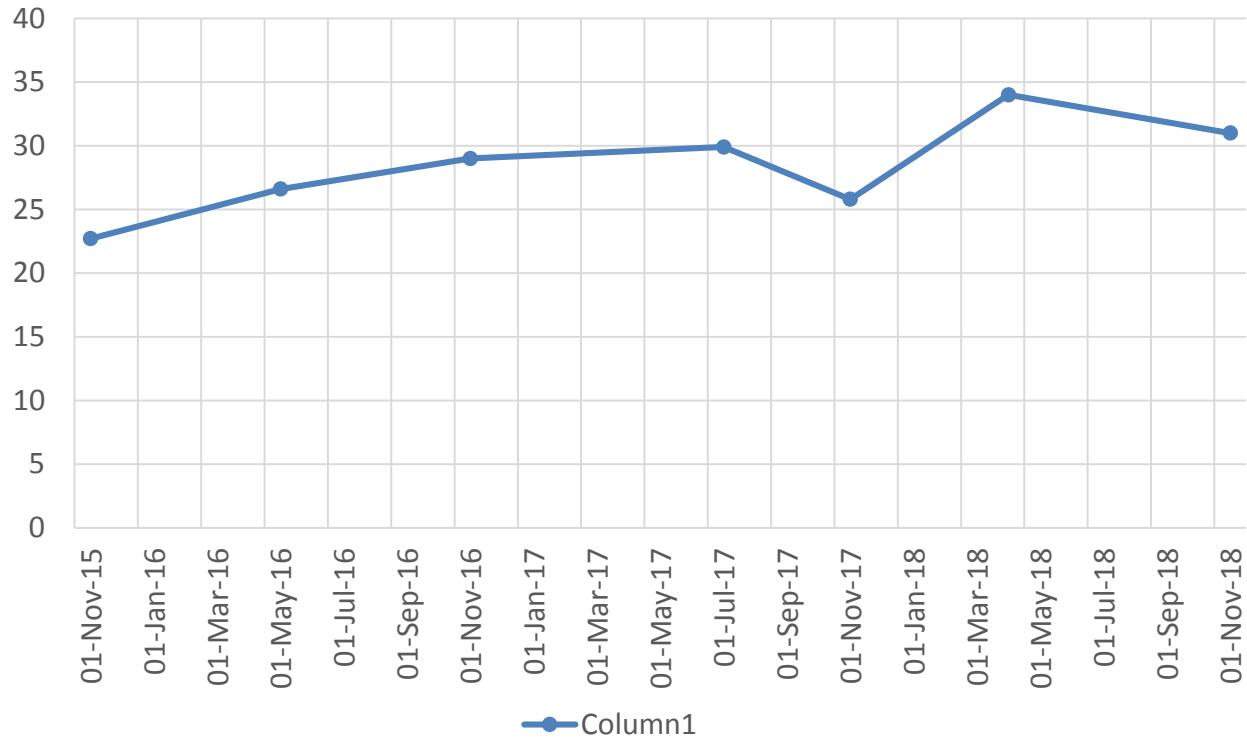
While services were improved, the critical need was identified as the delivery of service to higher acuity clients- Levels 5 & 6.

The data revealed that both agencies had been consistently providing care to clients with complex needs to ensure those clients' care needs were met.

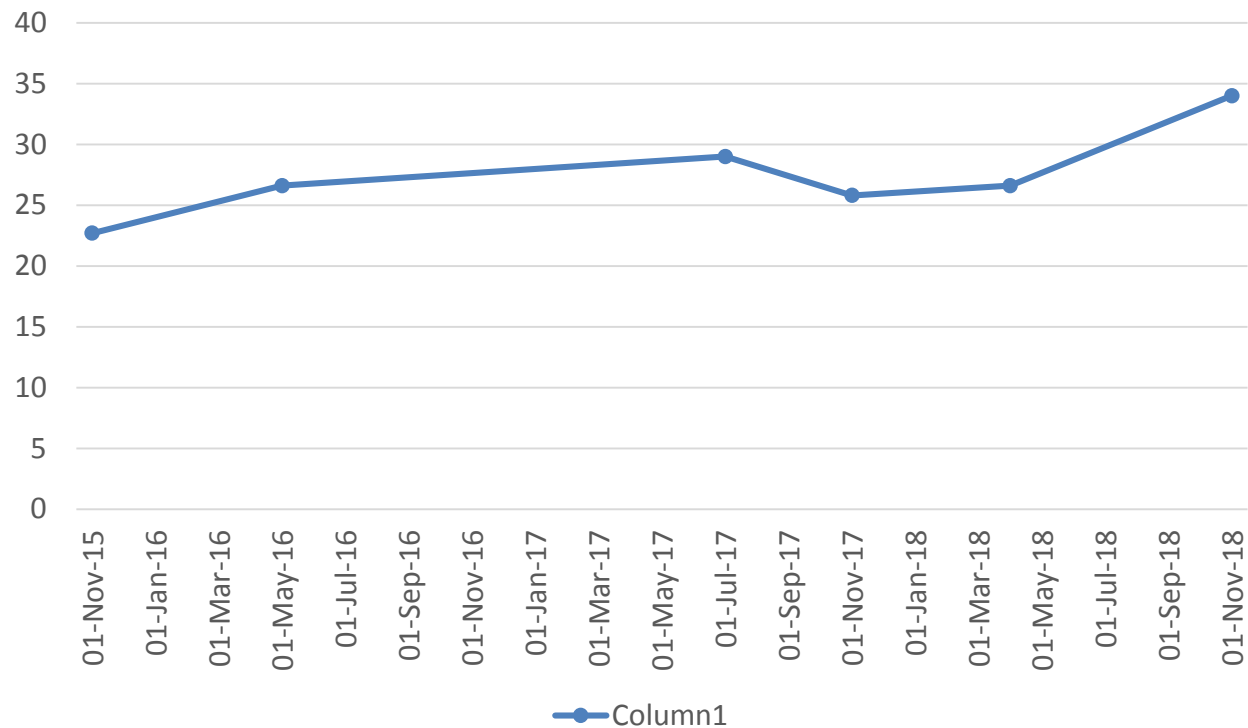
The Executive Director from CMHAK tracked the percentage of Level 5 clients who required a high level of care and this data was given to the LHIN 14.



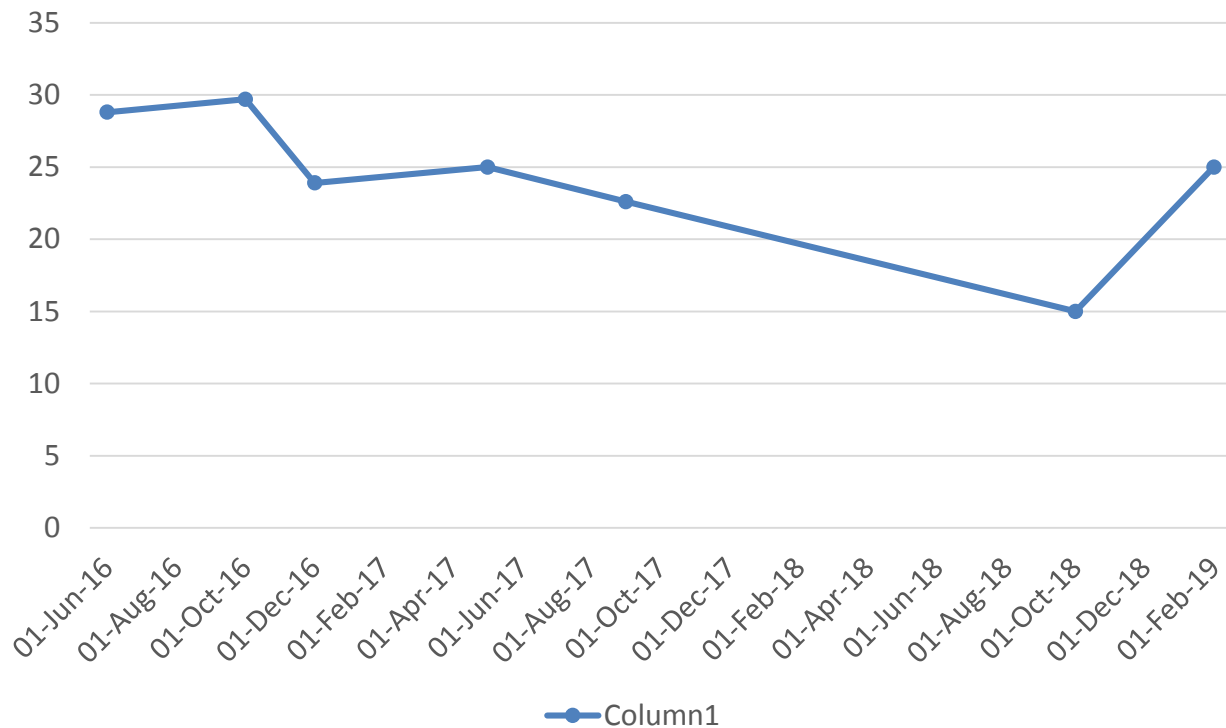
% of Level 5 LOCUS scores for Dual Diagnosis



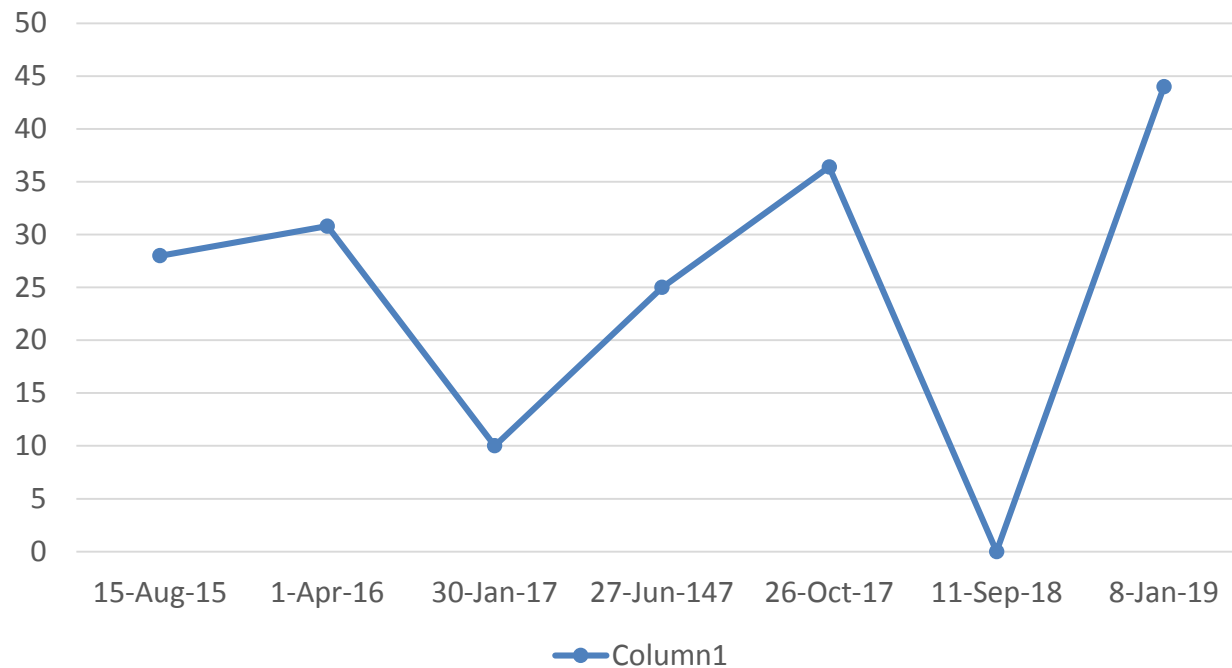
% of Level 5 LOCUS scores for CMHSS Program



% of Level 5 LOCUS scores for ACTT



% of Level 5 LOCUS scores for Forensic Case Management



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Ontario

North West Local Health
Integration Network

Réseau local d'intégration
des services de santé
du Nord-Ouest



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QUESTIONS

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