H·CARDD snapshot

Long-Stay Patients in Ontario Mental Health Beds with Developmental Disabilities

What is the project about?

In Ontario, Alternate Level of Care (ALC) is a designation given to patients who no longer require hospital care but cannot be discharged, typically because there is nowhere safe for them to go. Extended, unnecessary hospital stays can lead to negative outcomes for these patients, including physical deterioration, social isolation and loss of skills, as well as contributing to delayed access to care for other patients.

Adults with developmental disabilities and a mental health/addiction diagnosis are at higher risk of experiencing ALC days, yet little is known about patients with developmental disabilities currently in Ontario hospitals. This project aimed to better understand the prevalence and profiles of long-stay patients with developmental disabilities in Ontario mental health beds compared to those without developmental disabilities.

What did we do?

Scientists from ICES and the H-CARDD program analyzed data for all patients aged 18 and older who were occupying an inpatient mental health bed in Ontario as of September 30, 2023. They compared inpatients with and without developmental disabilities in terms of demographics, clinical characteristics, and healthcare use prior to hospitalization. The analysis focused primarily on people who had spent at least one year in hospital (defined as 'long-stay patients' hereafter), as these individuals are more likely to be classified as ALC.

What did we learn?

- As of September 2023, there were 555 patients with developmental disabilities who had been in a mental health bed for over a year. This group accounts for 28% of all long-stay mental health patients, even though adults with developmental disabilities comprise less than 1% of the population.

What you need to know:

- Over 1 in 4 long-stay patients in Ontario's mental health beds have a developmental disability.
- Long-stay patients with developmental disabilities face greater challenges for discharge.
- Intersectoral collaboration is needed to help transition these individuals into appropriate community settings and prevent them from being stuck in hospital.

- Few long-stay patients with developmental disabilities received care in specialized dual diagnosis units. Instead, they were spread across various mental health inpatient settings.
- Almost half (42%) of long-stay patients with developmental disabilities were in forensic beds.
- 22% of all long-stay patients in non-forensic beds had a developmental disability.
- One in three long-stay patients with developmental disabilities were autistic.
- At admission, a significant proportion of long-stay patients with developmental disabilities were living in group settings with non-relatives (42%).
- Long-stay patients with developmental disabilities were more likely to have characteristics that made discharge challenging compared to those without developmental disabilities, including: greater difficulty with activities of daily living, more severe cognitive impairment, and a lack of close family members/ friends to support their discharge.

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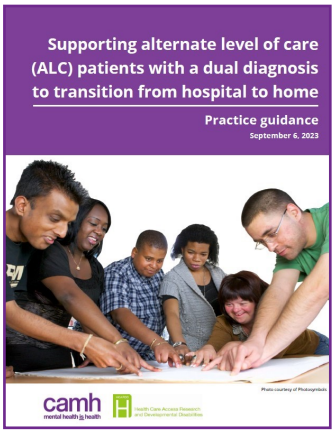
How can you use this research?

Successfully transitioning long-stay inpatients with developmental disabilities into the community requires consideration of their unique needs and collaboration between the hospital, community health, and developmental services sectors. Recently developed Ontario Practice Guidance identifies 10 components of successful transitions and outlines how providers, administrators and policy-makers in the health and developmental sectors can support improved transitions from hospital to home for people with developmental disabilities and mental health/addiction diagnoses. Future efforts need to focus on supporting these individuals' transition into the community, while also addressing the clinical and structural factors that contribute to their long-stay hospitalizations.

Do you want to know more?



For more information on supporting long-stay patients with developmental disabilities to transition out of hospital, visit the H-CARDD ALC project page.

For inquiries, contact Avra Selick (avra.selick@camh.ca) or Yona Lunsky (yona.lunsky@camh.ca).

Explore our Vignette Series to learn about key factors that helped six long-stay patients transition from hospital to communities across Ontario.

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Health Care Access Research and Developmental Disabilities

IC/ES

About H-CARDD

Health Care Access Research and Developmental Disabilities (H-CARDD) is a research program that aims to enhance the overall health and well-being of people with developmental disabilities through improved health care policy and services. H-CARDD research is conducted by dedicated teams of scientists, policymakers, health care providers, people with disabilities and families working collaboratively.

About ICES

This study was supported ICES, which is funded by an annual grant from the Ontario Ministry of Health (MOH) and the Ministry of Long-Term Care (MLTC), and the ICES Mental Health and Addictions Research Program. ICES is an independent, nonprofit research institute that uses population-based health information to produce knowledge on a broad range of health care issues.

Source Data Overview

This document used data adapted from the Statistics Canada Postal Code^{OM} Conversion File, which is based on data licensed from Canada Post Corporation, and/or data adapted from the Ontario Ministry of Health Postal Code Conversion File, which contains data copied under license from ©Canada Post Corporation and Statistics Canada. Parts of this material are based on data and/or information compiled and provided by CIHI and the Ontario Ministry of Health. These datasets were linked using encoded identifiers and analyzed at ICES.

The analyses, conclusions, opinions and statements expressed herein are solely those of the authors and do not reflect those of the funding or data sources; no endorsement is intended or should be inferred.