PROPOSAL

FOR AN INTEGRATED CONTINUING CARE PROGRAM

FOR CPC CHRONIC MENTAL PATIENTS

Working Group on CPC Continuing Care:

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1. Executive Summary

2. Introduction

2.1 CPC Working Group on Continuing care

2.1.1 Formation of Group

The Working Group was set up by Drs. Tempier and Olders, to facilitate the preparation of a comprehensive proposal for Day Treatment for CPC chronic patients, both anglophone and francophone.

2.1.2 Composition

The Working Group included representatives from each of the professions who will be involved in the proposed program: nursing, social work, occupational therapy, psychology, and psychiatry. The members were:

Louise de Bellefeuille, N
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Henry Olders, MD
Angelo Perna, M.S.W.
Raymond Tempier, MD

2.1.3 Process

The Working Group met weekly, using the outline of this proposal as an agenda. The points which were discussed each meeting were then incorporated into the proposal, which was then distributed to the members to obtain further feedback.

2.1.4 Reporting

2.1.4.1 Progress Reporting

Progress reporting to the CPC Task Force was through Elvira Maddoo, a member of the Task Force. Drs. Tempier and Olders kept the CPC Medical Staff informed on progress, via the weekly meetings of the Medical Staff. The Social Work Department meets every two weeks, and Angelo Perna undertook to keep his colleagues up-to-date. Caroline Greenwood reported to the biweekly meetings of the Occupational Therapy Department.

2.1.4.2 Approval of Final Report (Proposal)

2.1.4.2.1 By CPC Administration

2.1.4.2.2 By the Comité de Régie

3. History / Background of program

4. Goals and objectives (Philosophy and Orientation)

4.1 Integration into the Community

The philosophy adopted by the Working Group is that chronically mentally ill patients have the right to interventions which integrate them into the community to the extent possible, given the limitations imposed by the patient's illness, the resources available, and the degree of community acceptance. Thus, a physical location in the community is desirable.

4.1.1 Physical Location in the Community

Initially, the program could be set up in the facilities presently occupied by "l'Etape", if they will be available. A group within the continuing care organization should continue to seek a physical setting even more closely linked to the community, for example a duplex (leased or purchased) which could be remodelled to serve as a clubhouse.

4.1.2 Recognition of "Institutional Transference" to the Hospital

A number of clients of the existing Day Care Program identify very strongly with the security of the hospital, exemplified by the present setting in CPC basement. These clients might be extremely reluctant to participate in any program off the hospital grounds, and would need intensive

intervention to integrate them into a community-based program.

To meet the needs of these clients, this proposal calls for an "Annex" to the continuing care program, which will use the existing day care facilities in CPC basement. This Annex could be phased out, depending on the outcome of an ongoing assessment.

4.2 The Question of Language

Although many existing therapeutic programs within CPC are divided along linguistic lines (anglophone and francophone), the reality of living in any of the communities served by CPC is that bilingualism is a definite asset, if not essential in some cases (eg employment). This suggests that a more complete integration into the community would recognize the desirability of anglophones and allophones becoming comfortable with the culture, milieu, and language of the francophone segment of the community.

The proposed program will be linguistically integrated. It will offer interventions in both official languages, as well as language training to assist clients in becoming bilingual.

4.3 The "Fountain House" Psychosocial Clubhouse Model

Fountain House in New York City is a program for chronic mental patients, which has three major aspects:

As a club: Fountain House provides a setting where individuals will feel accepted, where they can have a say in what happens to them, where they can enjoy a sense of "community" (shared meals, a drop-in centre, recreational activities);

Pre-vocational training: Club members learn how to do the tasks required to run the club and its activities: clerical activities such as answering the phone, preparing a newsletter, keeping a membership list and statistics;janitorial and leadership skills needed to keep the facility clean and in good repair; cooking skills for the preparation of community meals and for a snack bar; management skills for budgeting, meal planning, purchasing, accounting, etc.

Transitional Employment program: Club staff members look for employers willing to contract with the club to provide entry-level jobs for club members, at the going rates of pay for such jobs. The club contracts to ensure that someone will be there to do the job, even if the original member is unable to work (eg due to illness); in such cases, staff arrange for another member to fill in, or fill in themselves if necessary. This assurance of employee availability is the "hook" necessary to get employers to participate.

4.4 Réadaptation

Le travail de réadaptation se base sur le renforcement des fonctions saines de l'individu qu'il peut encore utiliser. Il se base sur le modèle de réadaptation des handicapés. Il se concentre sur le «traitement» des signes négatifs ou déficits: a-motivation, a-pragmatisme, a-socialisation etc... Il s'oriente vers 2 pôles: le développement des habiletés de vie quotidienne ou capacité de l'individu à fonctionner et l'augmentation du réseau de support.

4.4.1 Le développement des habiletés de vie quotidienne

Un processus graduel où les ex-patients apprennent des notions de base dans 9 domaines: l'alimentation, et la confection des repas, les travaux domestiques (ménage), le budget, l'utilisation d'un moyen de transport, le retour au travail, l'organisation des loisirs, l'utilisation des médicaments, la présentation.

Le programme sera une «école» qui fonctionnera en ateliers de type Liberman avec principes de base de type apprentissage social.

4.4.2 L'augmentation du réseau de support

Cet aspect du programme aura autant d'importance que le premier et on mettra à l'oeuvre une série d'activités psychoéducatives destinées aux familles naturelles, et aux familles d'accueil et personnes de l'entourage des bénéficiaires admis au programme; cela visera le renforcement de l'aide apportée, en dehors des professionnels du programme et permettra une meilleure insertion dans le milieu naturel. Les activités psychoéducatives tendent à diminuer les préjugés, les attitudes de rejet que les non professionnels vivant à côté des bénéficiaires peuvent entretenir et de ce fait limiter les possibilités de réinsertion.

Le travail de «PSYCHOEDUCATION» ou d'éducation et d'entraide sera basé sur l'écoute des parents et amis, sur la diffusion d'une information pertinente. Il se coordonnera avec divers autres

programmes en cours de réalisation dans le sud-ouest (INFO-PSY, Groupe de parents de l'ACSM etc...). Il servira de première prise en charge familiale; dans toutes nos activités nous privilégierons une participation active des familles et des non professionnels à nos activités psychoéducatives mais aussi en rapport avec le travail général de réadaptation.

4.5 Individualized Approach

New clients will be assessed on an individualized basis, and treatment programs individualized to meet their needs. All cases will be reviewed periodically to ensure that treatment plans are updated as necessary.

4.5.1 Individualized Assessment

New clients will be assessed using a combination of standardized assessment instruments to assess social and occupational functioning, and an interview with members of the team. Where possible, data gathering will be assisted by the use of computer questionnaires.

4.5.2 Individualized Treatment Planning

Following the assessment process, a written treatment plan will be generated for each client, taking into account the client's strengths and deficits, the program's resources, and the availability of other resources in the community or the hospital. The plan will identify the individuals responsible for implementing and monitoring various aspects.

4.5.3 Monitoring

Each case will be reviewed periodically in team meetings, to ensure that treatment plans continue to reflect the client's needs and progress.

4.6 Research

The Program will be a setting where clinical research can flourish. Using tools such as patient evaluation instruments applied at intake, during treatment, and at discharge and followup will permit outcome studies to be carried out. Computerized demographic, statistical, and administrative data will be available for research purposes as well.

4.7 Quality Assurance

It is planned that demographic, statistical, and administrative data will be computerized, thus permitting utilization reviews and quality assurance audits to be performed periodically as part of the normal activities in the program. Outcome quality assurance is not yet well developed in psychiatry, and additional research will need to be done before adequate schemas can be put in place.

4.8 Teaching

The program will provide training to psychiatry residents (Continuing Care rotation, as well as electives); medical and nursing students; occupational therapy, psychology, and social work interns; and to staff from other institutions who wish to import similar programs to their own setting.

There will also be a strong emphasis on inservice education of Program staff, particularly in Rehabilitation.

5. Population served

5.1 Source of patients

Patients will be referred by Douglas Hospital CPC inpatient units, day hospital units, and by outpatient clinics (Verdun and LaSalle). These patients can be followed psychiatrically either by the Continuing Care Centre program or by the referring program. Patients can be referred to the Psychosocial Club by other agencies in the community (eg private psychiatrists, GP's, etc) in which case the referring source will undertake to follow the patient medically and psychiatrically.

5.2 Catchment areas

Area "A" of Montréal, comprising Verdun, LaSalle, Ville Emard, Côte St-Paul, and Pointe St-Charles.

5.3 Characteristics of population

5.3.1 age

Clients between 18 and 65 years of age will be accepted.

5.3.2 Language

Francophones, Anglophones, and allophones will be served in both official languages. Core rehabilitation programs and groups, as well as psychiatric followup, will be available in French and English, while socialization and outing groups will be run bilingually. Language training will be provided as a component of social rehabilitation and reintegration into the community.

5.3.3 Other characteristics

Clients of the program can be grouped into two categories:

5.3.3.1 Institutionalized patients

These patients fall into three categories:

Patients who are marginally able to live outside the hospital, based on their being able to come to the hospital almost daily for meals and familiar surroundings, and the availability of stable "attachment figures" to deal with crises, arrange for money from the social service trust fund, etc. Many of these patients are too withdrawn even to participate in social activities. These patients would decompensate if existing day care services were suddenly withdrawn.

Patients who work in the various Industrial Therapy workshops and activities in the hospital, and depend on existing day care services for social activities, clinical followup in some cases, money management services, meals, and crisis intervention. If existing day care services were to be discontinued in the new integrated Continuing care, these patients would use the Emergency Room for crisis intervention in the absence of comparable services.

Patients who function relatively well in the community (compared to the first two groups) and who make active use of groups and other rehabilitation activities of Day Care I. Some of these individuals could function as volunteers within the proposed continuing care program, or "graduate" to both volunteer and paid work outside of the hospital.

5.3.3.2 Non-institutionalized mentally ill individuals ("Young Chronic Patients")

This population of patients, now emerging, are most often schizophrenic, but many suffer from personalitiy disorders. They have never been institutionalized. They can be found in all types of service settings, but many do not use any service system - this applies to vagrant "street people". Many are dealt with by the criminal justice system. Drug abuse can be a major factor; there is a high risk for suicide in these individuals with fragile egos and difficulty dealing with rejection. Most are active demanders of services, but compliance with treatment plans is often poor. They often provoke anger and frustration in staff.

The lack of family support which is frequently found, combined with high mobility, means that providing comprehensive care becomes very difficult. Housing is often important.

These individuals frequently fail to see themselves as ill; they may refuse to associate with other mentally ill patients, referring to them as "crazies".

5.3.4 inclusion criteria

Individuals who wish to become members of the psychosocial club or receive services of the continuing Care Centre will be individually assessed regarding their suitability. Diagnosis will not be a criterion for inclusion or exclusion. Instead, individuals who have experienced long-term impairment in social or occupational functioning, or for whom long-term impairment is predicted based on their illness, will be accepted based on their need for and capacity to benefit from the services offered. In general, such individuals will be suffering from chronic psychotic illnesses.

5.3.5 exclusion criteria

Exclusion criteria will include:

patients with uncontrollable violent behaviour

individuals with chronic suicidal behaviour

individuals with self-mutilative behaviour

patients in an acute phase of their illness or in crisis

individuals with substance abuse as the primary problem

5.3.6 expulsion criteria

Clients will be made aware of the types of behaviours which would result in their being expelled from the program; for example, bringing drug or alcohol abuse into the program.

6. Treatment

6.1 Treatment services

The services to be offered by the integrated continuing care program fall under two general headings: Psychosocial Club, and Continuing Care Centre. The Club, which is intended to operate relatively autonomously under the control of its members, will receive guidance, support, management, and training from the professional staff. It will provide services to its members which include a drop-in centre, recreational activities and outings, meals, snack bar, store, a newsletter, a transitional employment program, and on-the-job rehabilitation experiences.

The Continuing Care Centre will operate in a more traditional "caregiver-client" mode, providing services such as case management, psychiatric followup, rehabilitation training, and psychoeducation.

6.1.1 Setting

The proposed integrated continuing care program will be located initially in two physical settings.

6.1.1.1 Continuing Care Centre

Located in the community, central to the two main population centres of Verdun and LaSalle, this Centre should be sited close to public transport, in a commercial area near to post office, stores, and recreational facilities. The Continuing Care Centre program including the clinic will be located here, and also the Psychosocial Club.

If available, the building presently used by "l'Etape" would meet the needs of the Continuing Care Centre. Alternatively, a duplex could be leased or purchased and then remodeled to serve as the Centre.

6.1.1.2 Hospital Annex

To meet the needs of those patients in category 1 (and some in category 2) above, we propose that some of the integrated continuing care program functions be located within the hospital. This "Annex" needs day room and lounge space, and also offices. The existing CPC Day Care I facilities are suitable.

This Hospital Annex is felt to be necessary only initially. As clients are gradually integrated into the community-based facility, the need for these services within the hospital will hopefully disappear, so that the annex can be closed and its staff repatriated to the community-based facility.

6.1.2 "Psychosocial Club" Activities

Using the psychosocial club model as developed at Fountain House in New York city and subsequently employed in hundreds of clubs all over the United States, the Integrated Continuing Care Program will provide support for a club operated primarily by its members. The club will provide a number of socialization activities, including a drop-in centre, recreational and sports activities, and organized outings. To keep its members up-to-date and involved, it will publish its own newsletter. Nutritional needs will be met through provision of one or two daily meals, occasional "special event" community meals, and a snack bar.

6.1.2.1 money management

Instruction in budgeting, saving, using banks and other financial institutions, will be provided. The Club will also provide money management services for its members, which will operate in a similar fashion to the Social Service Trust Fund. Members will sign an agreement with the club, who will then receive the individual member's welfare cheque or other source of income, and then disburse funds to pay for rent, groceries, etc. according to the budget previously agreed to. Of course, members will be able to cancel the arrangement at any time.

6.1.2.2 Store

If space and staff resources permit, the Club will operate a store, where both members and non-members will be able to purchase new and used household items and clothing.

6.1.2.3 Prevocational Training

The operation of the Club will involve the regular performance, by Club members, of a number of semi-skilled tasks. Training in performing these jobs will be provided by both support staff and by other Club members, in the "sheltered workshop" environment provided by the Club itself. The tasks fall into the following occupational categories:

6.1.2.3.1 Clerical

Clerical tasks include maintenance of Club records and accounts, serving as receptionist, typing of correspondence and the Club newsletter, and (if permitted by resources) doing word processing in a Club-operated Word Processing Centre (which could take in contract work from companies and individuals).

6.1.2.3.2 Housekeeping and Maintenance

The Clubhouse will require a team of workers to provide janitorial and mantenance services. Such skills could also be marketed to homeowners and small businesses.

6.1.2.3.3 Dietary

To provide daily meals and to operate the snack bar will require individuals to plan menus, purchase supplies, cook, serve meals and snacks, and supervise these activities.

6.1.2.3.4 Retailing

Operating the store and snack bar will require skills in retailing, purchasing, sales, bookkeeping and management.

6.1.2.4 Transitional Employment

An important aspect of the Fountain House model is its Transitional Employment Program. Staff contract with outside employers to provide entry-level jobs, at the going pay rates, for Club members. To ensure that the employer is not left "in the lurch" if the Club member is unable to work for any reason, including relapse and rehospitalization, the Program staff will train more than one individual to perform the work, and if necessary go in to do the job themselves if necessary.

6.1.3 "Continuing Care Centre" Activities

6.1.3.1 Case Management

6.1.3.1.1 Management of Finances
6.1.3.1.1.1 Assistance with Budgeting
6.1.3.1.1.2 Coordination with Welfare Officers
6.1.3.1.1.3 Social Service Trust Fund
6.1.3.1.1.4 Coordination with Curators

6.1.3.1.2 Housing
6.1.3.1.2.1 Supervised Apartments
6.1.3.1.2.2 Foster Care
6.1.3.1.2.3 Pavilions

6.1.3.1.3 Coordination of Follow-Up
6.1.3.1.3.1 Psychiatric Follow-Up

The majority of Continuing Care Centre clients will be followed up psychiatrically by their own treating teams in the CPC Outpatient Clinics. Others will receive care from the referring individual or agency (for example, private psychiatrists or family practitioners, other hospitals or CLSC's). Finally, some clients will be followed by the part-time psychiatrists and their teams, at the Continuing Care Centre itself.

6.1.3.1.3.1.1 Patients followed by Clinique Externe teams
6.1.3.1.3.1.2 Patients followed by private psychiatrists and GP's
6.1.3.1.3.2 Medical Follow-Up

6.1.3.2 Psychiatric Care

The clients who receive psychiatric care within the Continuing Care Centre will have access to the following psychiatric services:

6.1.3.2.1 Intake Evaluation

After referral, the new client will be assessed by a psychiatrist.

6.1.3.2.2 Regular Assessments by Nurse Clinicians

Clients are seen on a regular basis (usually weekly to monthly) by nurse clinicians in the Continuing Care Centre Clinic, who carry out assessments of clinical status.

6.1.3.2.3 Medication Clinic

Clients are also seen periodically (every month to every three months) by either a psychiatrist, by a psychiatric resident, or by a medical student under the direct supervision of a resident or psychiatrist. Nurse clinicians participate in these clinics, both in assessing clients and in the teaching of residents and medical students.

6.1.3.2.4 Administration of Injectible Medications

Depot antipsychotic medications are administered by nurse clinicians, generally as part of the regular assessment visits, at intervals ranging from one to six weeks.

6.1.3.3 Rehabilitation

6.1.3.3.1 Social Skills Training
6.1.3.3.1.1 Groups
6.1.3.3.1.2 Individual Sessions

6.1.3.3.2 Training in Activities of Daily Living
6.1.3.3.2.1 Shopping
6.1.3.3.2.2 Cooking
6.1.3.3.2.3 Using Public Transportation
6.1.3.3.2.4 Budgeting
6.1.3.3.2.5 Management of Medication
6.1.3.3.2.6 Cleaning
6.1.3.3.2.7 Use of Leisure Time

6.1.3.4 Psychoeducation

6.1.3.4.1 of Patients

6.1.3.4.2 of Families

6.1.3.4.3 of the Community

6.1.4 Functions of the "Hospital Annex"

6.1.4.1 money management

For patients on the Social Service Trust Fund, Annex staff will provide daily or weekly cashiers' slips.

6.1.4.2 case management

For example, provision of bus tickets or passes, or dealing with crises as they arise (for example, housing problems).

6.1.4.3 medication management

Administration of injectable long-acting medications.

6.1.4.4 meals

Lunches are provided five days per week, Monday to Friday.

6.2 Administration of program

6.2.1 Management Structure

The Continuing Care Centre program will function using the "team" concept. Each multidisciplinary team will be responsible for a different set of functions and roles within the Continuing Care Centre, although they may overlap with respect to their clients.

6.2.1.1 Functional Teams

The following teams will be formed:

6.2.1.1.1 Club Support Team

This team's role will be to support the functioning of the psychosocial club. As such, it will operate largely in an advisory, teaching, consultation mode to the club and its members, instead of a caregiver-patient relationship.

The Club Support Team will provide management expertise to the club's executive. It will also exercise control over the club, in that two team members will sit on the club's board of directors, with a limited veto power.

In terms of rehabilitation, this team will be involved in teaching job skills related to the club's day-to-day operations, such as: club receptionist (answering the telephone, taking messages, typing, filing, etc.); short order cook for the snack bar; cashier; salesperson for the club store; meal planning, shopping, meal preparation; housekeeping; managerial skills, and so on.

6.2.1.1.2 Employment Team

The Employment Team (for the Transitional Employment Program) will be responsible for finding employers with entry-level jobs; contracting with them; and training employees and backups. Team members will function as "case managers" around work-related issues for clients involved in the Transitional Employment Program. When necessary, team members will fill in for absent or sick clients in their jobs, if no other replacements can be found. The team will either have or develop expertise in helping clients in career planning, preparing resumes, finding jobs, successful interviewing, and self-organization skills needed to keep a job.

6.2.1.1.3 Clinical Team

The Clinical Team will be responsible for psychiatric followup of patients, including clinical assessment, prescription of medications, supportive psychotherapy, and administration of depot injectable antipsychotic medication.

This team will also be involved with the Hospital "Annex": those patients who cannot immediately be "weaned" from the existing CPC Day Care, and who will continue to come to the hospital for meals, money management, crisis intervention, and injection of medication.

The team will be based in the Continuing Care Centre, but some team members will be in the Hospital Annex on a part-time basis. Clinical coordination with the inpatient units, day hospitals, and outpatient clinic teams will also be performed by Clinical Team members.

6.2.1.2 Matrix Management

As is the case throughout Douglas Hospital, the various professionals working in the integrated continuing care program will be responsible both to their own professional departments (ie departments of psychology, social work, nursing, and occupational therapy), and to their team leaders and Continuing care coordinator.

6.2.2 Documentation and Medical Records

6.2.2.1 For Patients Followed by the Clinical Team

For those patients receiving psychiatric care and followup from the Clinical Team, the patient charts which are ordinarily kept in the outpatient clinics for those patients will be physically transferred to the Continuing Care Centre.

6.2.2.2 For Other Clients

The majority of the Continuing Care Centre clients and club members will not be followed by the integrated continuing care program's Clinical Team. Thus, an official medical record will not be maintained for these clients by Continuing Care Centre staff. However, a dossier will be opened and maintained for each client, containing referral information and correspondence, assessment results, individualized intervention plans, progress notes relating to rehabilitation activities, and annual summaries. These dossiers, while the property of the centre, will be subject to rules of confidentiality and disclosure as if they were medical records.

6.2.3 Meetings

6.2.3.1 Continuing Care Centre Meetings

6.2.3.1.1 Management Meetings

6.2.3.1.1.1 Executive Meetings

An executive committee, consisting of the Continuing Care Centre Coordinator and the Team Leaders, will meet weekly to deal with management issues, such as budgets, staffing, facilities, etc.

6.2.3.1.1.2 Centre Management Meetings

Each month, the entire staff of the Continuing Care Centre will meet for the purposes of communicating information, discussing strategy and planning, and so on. An agenda will be circulated prior to each meeting, and minutes distributed afterwards.

6.2.3.1.2 Coordination Meetings

On a periodic basis (possibly weekly) a meeting will be held attended by representatives from each team, to discuss and plan admissions, discharges, and referrals, as well as coordinate transfers of clients between teams. This meeting will also be the focus of coordination between inpatient units, day hospitals, and outpatient clinics.

6.2.3.2 Team Meetings

Each team will meet on a weekly basis to discuss and plan team activities and review interventions with clients. All the clients being followed by a team will be discussed on a periodic basis, so that each client's intervention plan can be reviewed at least once every three months.

In the case of the Clinical Team, patient reviews at team meetings will result in progress notes being written in the chart.

6.2.3.3 Case Rounds

Once monthly, a teaching case rounds will be held. A given client will be discussed, with the various professionals involved with the client making brief presentations on the case from the point of view of their discipline. Responsibility for presenting cases will rotate between teams, who will prepare a short literature review to illuminate the particular issues.

6.2.4 Quality Assurance

6.2.4.1 Process Assessment

6.2.4.2 Outcome Assessment

7. Education

7.1 Training of Permanent Staff

7.1.1 Startup Training

7.1.2 Orientation of New Staff

7.1.3 Inservice Education

7.1.4 Ongoing Supervision

7.1.5 Workshops

7.2 Education of Professionals

7.2.1 Nursing Students

7.2.2 Medical Students

7.2.3 Psychiatric Residents

The Continuing Care Centre will form an integral part of the Continuing Care Rotation for psychiatric residents. At any given time, the Centre may have up to two residents who will be associated primarily with the Clinical Team, under the clinical supervision of psychiatrists. Residents will run clinics, together with nurse clinicians;

participate as trainers in rehabilitation activities; function as group therapists for supportive group psychotherapy; and assist in psychoeducational activities with patients, families, and the community.

7.2.4 Psychology Interns

7.2.5 Occupational Therapy Students

7.2.6 Social Work Students

7.3 Regeneration

7.3.1 Training of Teams from other Institutions

7.3.2 Consultation

8. Research

9. Evaluating

10. Average length of stay

11. relationship of program to other department / hospital programs

12. resources

12.1 Staff

12.1.1 Teams

There will be initially only one team, the Clinical Team, whose members will be responsible for psychiatric followup of patients, rehabilitation activities in the Continuing Care Centre, and staffing of the transitional services in the "Hospital Annex".

A second team will be formed, the Club Support Team, which will initially plan the formation of the psychosocial club, recruit and train prospective members, seek funding, obtain space, furnishings, and equipment. and finally, provide assistance to club members in operating the club.

The third team, the Employment Team, can begin its operations as soon as the club has sufficient members functioning at a sufficiently high level for a Transitional Employment Program in the community to be viable.

12.1.2 Types of Staff

12.1.2.1 Nurse Clinicians

12.1.2.2 Occupational Therapists

12.1.2.3 Rehabilitation Monitors

12.1.2.4 Social Workers

12.1.2.5 Psychologists

12.1.2.6 Case Managers

12.1.2.7 Volunteers

This could include relatively well-functioning patients.

12.1.2.8 Psychiatrists

12.1.3 Numbers of Staff

12.1.3.1 By Client Number

12.1.3.2 By Shift

12.1.3.3 By Location

12.2 Equipment

12.3 Space (Facilities)

12.3.1 Community Clubhouse

12.3.1.1 Floor Area

12.3.1.2 Room Types

12.3.1.2.1 Lounge

12.3.1.2.2 Kitchen

12.3.1.2.3 dining Room

12.3.1.2.4 Snack bar and Store

12.3.1.2.5 Clerical Area

12.3.1.2.6 Music Room

12.3.1.2.7 Workshop

12.3.1.2.8 Conference Room

12.3.1.2.9 Staff Offices

12.3.1.2.10 Group Rooms

12.3.1.2.11 Bathrooms

12.3.2 Hospital Annex

12.3.2.1 Group Rooms

The annex will require a day room / lounge for the approximately 40 anglophone and estimated 20 francophone clients who will need its services.

12.3.2.2 Clinic

For interviewing patients, administering injections, etc. the annex will need four offices for nurses, as well as a secretary's office.

12.4 Budget

12.4.1 Funding

12.4.1.1 Start-Up Funding

12.4.1.1.1 CRSSS

12.4.1.1.2 Douglas Hospital

12.4.1.1.3 Corporation of Douglas Hospital

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12.4.1.2.1 Douglas Hospital

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