Breakout Session #1, option 2: Mental Health, Social Isolation & Addictions

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SHS/Circle of Care - Care Navigator/Social Worker

Sinai Health System

Objectives for the session:

- How to help patients cope with social isolation – practical tips and strategies for at home practice, particularly in the face of another wave and fall/winter seasons
- How to approach and address issues of self-harm and addiction in patients
- Health Provider and caregiver well-being
- How to work together in interprofessional teams during a pandemic and look out for each other's well being

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Background and context

- Extra-ordinary times
- A lot of unknowns
- Unable to do what we normally do

- Analogies of what we are experiencing…. What is yours?
- Self care is always important but even more NOW!

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RUNNING ON EMPTY….

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Sinai Health Mental Health Resources:

- 4-7-8 breathing with Dr. Ben Rosen

https://www.youtube.com/watch?v=Tsy44iWbNhw&feature=youtu.be

- Sinai Health Video Series for Schools

https://www.sinaihealth.ca/school-educator-videos/

- Steps to Coping with Dr. Bob Maunder and Dr. John Hunter

https://www.youtube.com/watch?v=KOFoWP35gTU

- Applying psychotherapeutic principles to bolster resilience among health care working workers during the COVID-19 Pandemic by Drs. Rosen, Preisman, Hunter, Maunder

https://psychotherapy.psychiatryonline.org/doi/10.1176/appi.psychotherapy.20200020

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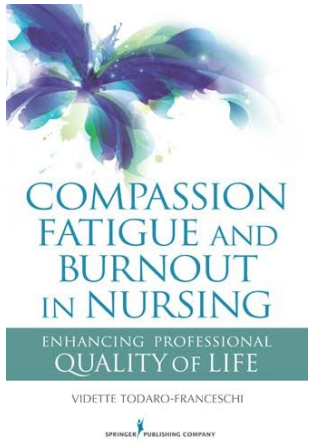
Compassion Fatigue

- Profound physical and emotional exhaustion.
- Can impact anyone in the “caring” professions.
- It’s an erosion of empathy, hope and compassion for others and for ourselves.
- Described as the “cost of caring”.



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Resilience

- Refers to strengthening for when the going gets tough and being able to bounce back from difficulties.
- Research has shown that in order to manage the high stress of the work that we do, we need to cultivate resiliency.
- Our patients are more and more complex and they aren't going to stop having difficult lives and situations.

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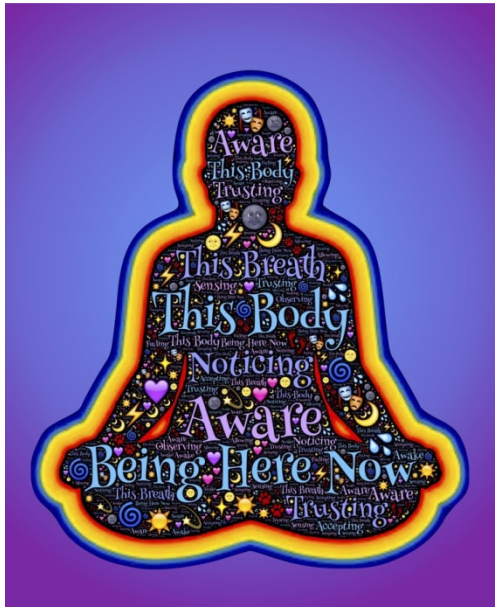
5 Strategies to Manage Compassion Fatigue

1. Understanding what's happening to you.
2. Take stock of stressors and self-care and identify your warning signs.
3. Create or restore social supports (team support; recognize when others feel stress).
4. Get support before it's a crisis.
5. Make a concrete commitment.



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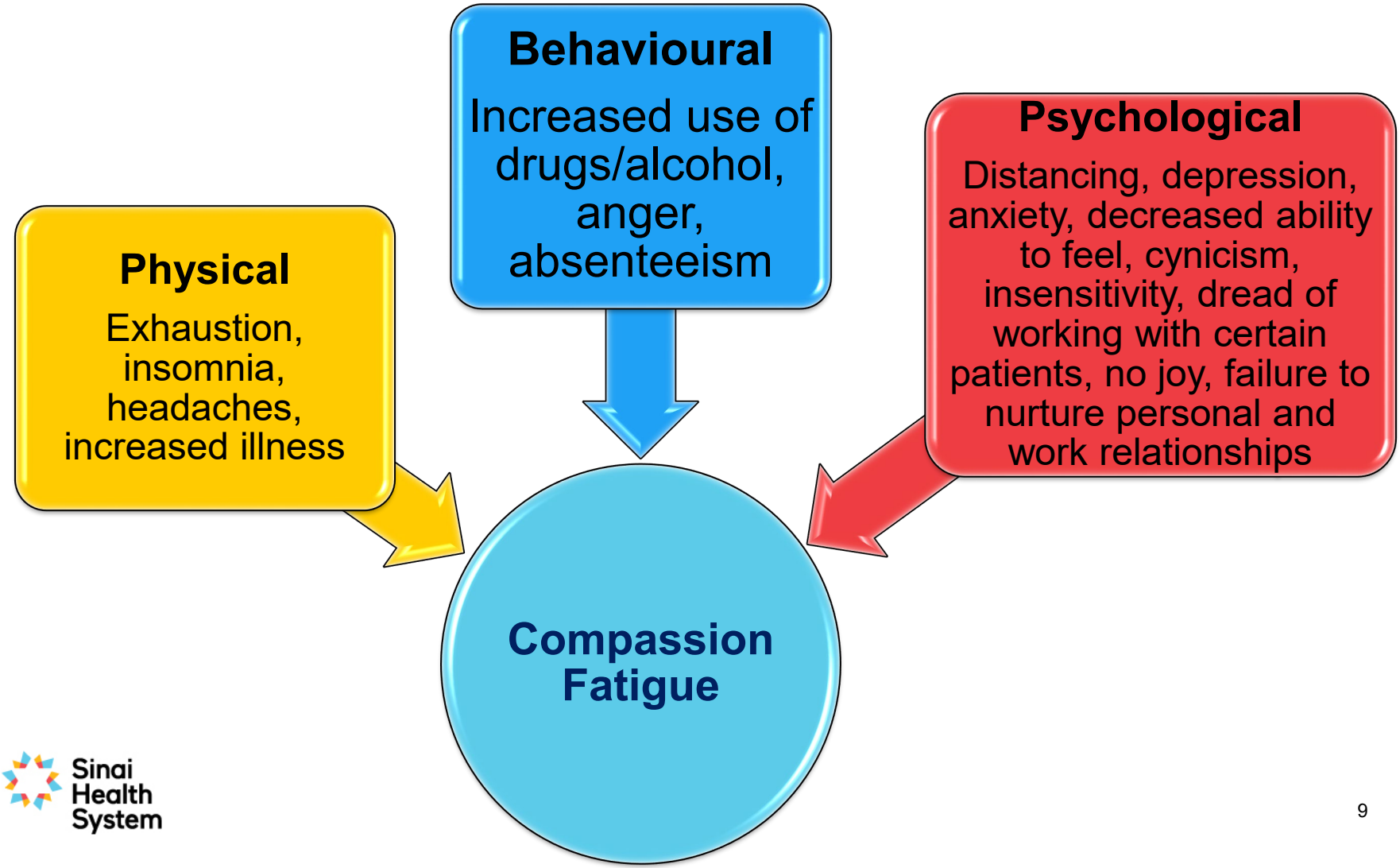
Signs & Symptoms of Compassion Fatigue



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5 Strategies to Manage Compassion Fatigue

1. Understanding what's happening to you.
2. Take stock of stressors, identify your warning signs and think about self care strategies.
3. Create or restore social supports (team support; recognize when others feel stress).
4. Get support before it's a crisis.
5. Make a concrete commitment.

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Transition over to Omar and Anna….

- Suicide, self harm and addictions
- Social isolation

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Concurrent Breakout Session #2:

Mental Health, Social Isolation, and Addictions

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Department of Psychiatry

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Conflict of interest disclosure

- None

Objectives

- How to prioritize provider well being
- **How to monitor self-harm and addictions in older patients**
  - Overview of suicide risk assessment in the elderly
  - Overview of substance use disorders in the elderly
  - Case
- Tips and management strategies to help older patients cope with social isolation

Caveat

- This is **not** a detailed review of self harm, suicide, or substance use disorders in older adults
- Please see references for further details and resources

Terminology

Suicide attempt:

- Self-inflicted act that is intended to result in death
- **Intent** is to die
- **Passive** suicidal ideation: The wish or hope that death will come
  - e.g. “I would be better off dead”, “I want to go to sleep and never wake up again”
- **Active** suicidal ideation: Thoughts of taking action to kill oneself
  - e.g. “I want to kill myself”, “I want to end my life and die”
  - Evaluate plan, means, lethality, preparations, strength of intent, impulsivity

Self-harm behavior:

- Intentional and often repetitive behavior that involves the infliction of harm to one’s body without an intent to die
- **Intent** is not to die but to provide temporary relief for psychological distress
- Accidental death or serious injury may result

Suicide rates by age

- Suicide rates are lowest in persons under 15 years and highest in those 70 years and older
- 2018 Statistics Canada

	65-74 years	75-84 years	85+ years
Cause of death (rank)	12	17	25
Number of deaths	332	182	77

- For every 2 to 4 elderly who attempt suicide, 1 is successful; in adolescents and young adults, there may be as many as 200 suicide attempts for each suicidal death
  - Frailty – less able to tolerate violent self harm injuries
  - More lethal means – e.g. US 71.4% geriatric vs 46.7% younger commit suicide with firearms
  - Less ability to survive or recover

Clinical evaluation of suicide risk

Purpose: To identify risk and protective factors with a focus on identifying **modifiable targets for intervention**

Principles of suicide risk assessment

1. The therapeutic relationship

- Listen empathically with a calm tone of voice
- Modelling behavior may assist in de-escalating the situation

2. Communication and collaboration

- With the patient, within and between care teams, with patient's informal support network
- Our personal feelings of overwhelm or frustration may impact the relationship

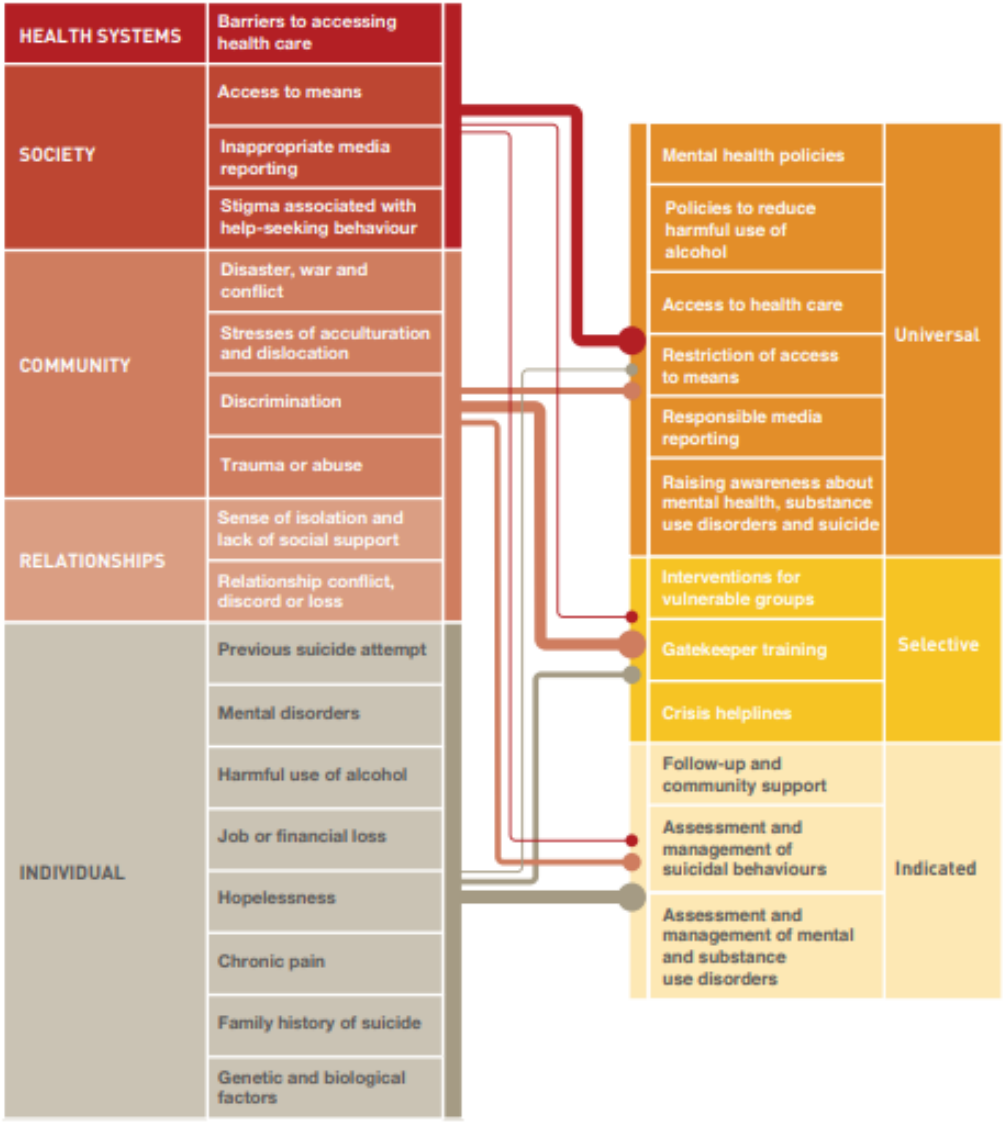
3. Documentation

- Overall level of suicide risk, history of suicide attempts/self harm, risk and protective factors, etc.

4. Cultural awareness

Perlman CM, Neufeld E, Martin L, Goy M, & Hirdes JP. 2011. Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health care Organizations. Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute.

Key risk factors for suicide aligned with relevant interventions



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Key risk factors for suicide aligned with relevant interventions: Effect of COVID-19

COVID-19

Reviewed in: Wasserman D, Iosue M, Wuestefeld A, Carli V. Adaptation of evidence-based suicide prevention strategies during and after the COVID-19 pandemic. 2020. World Psychiatry.

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Protective factors

- Social support and family connectedness
- Pregnancy, parenthood
- Religiosity and participation in religious activities

Substance use disorders in older persons

- Compared to earlier cohorts, baby boomers have high rates of earlier substance use (47.4% vs 19.3%) – “emerging epidemic”

TABLE 1. List of Current Known Risk Factors for Continued Use of Substances Into Late Life or Initiation of Substance Use in Later Years of Life

Risk Factors for Substance Use Disorders in Late Life
Male
White or black race
High school education or beyond
Unmarried or divorced
Depression or bereavement
Chronic physical illness or pain
Disability
Loneliness or social isolation
Being a caregiver
Change in living situation or career
Not religiously active

TABLE 2. Estimated Prevalence of SUDs in Later Years of Life by Substance. Rates Vary Significantly Based on the Study Design and Criteria Used to Define Disease. Given the Lack of Uniformity in These Measures Even Across the Same Substance, the Best Available Data Suggests a Wide Range of Possible Prevalence Rates

Estimated Prevalence Rates of Substance Use in the Elderly	
Alcohol	2.1%–67%
Tobacco	4%–22%
Cannabis	<1%–6.9%
Illicit, except marijuana	<1%–53.8%
Marijuana	2.9%–3.9%
Benzodiazepine	1.7%–11.4%
Opiates	<1%–21%

Yarnell S, Li L, MacGrory B, Trevisan L, Kirwin P. Substance use disorders in later life: A review and synthesis of the literature of an emerging public health concern. 2020. Am J Geriatric Psychiatry.

DSM-V Substance use disorder

A problematic pattern of use leading to clinically significant impairment or distress is manifested by two or more of the following within a 12-month period:

- 1. Larger amounts or over a longer period than was intended.
- 2. Persistent desire or unsuccessful efforts to cut down or control use.
- 3. A great deal of time is spent in activities necessary to obtain, use, or recover from the substance's effects.
- 4. Craving or a strong desire or urge to use the substance.
- 5. Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.
- 6. Continued use despite having persistent or recurrent social or interpersonal problems.
- 7. Important social, occupational, or recreational activities are given up or reduced because of use.
- 8. Recurrent use in situations in which it is physically hazardous.
- 9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- 10. Tolerance.
- 11. Withdrawal.

Severity:

- Mild – Two to three criteria
- Moderate – Four to five criteria
- Severe – Six or more criteria

Screening and diagnosis tips

- Challenged by lack of social cues, job loss, legal involvement, medication conditions may mask substance use
  - Misconception that physical and cognitive changes are related to normal aging rather than potential substance use
- US-NIAAA EtOH > 65 yo risk threshold: 4/day or 7/week
- Consider:
  - History of SUD and past treatment
  - Route of administration, amount, frequency, pattern
  - Medical and psychiatric comorbidities
  - Risk/reporting – driving, child at risk
  - Patient's perception and readiness to change
  - Pharmacotherapies can be quite helpful for some substances (tobacco, alcohol, opioids)

Motivational interviewing

- A directive, patient-centred counseling approach that helps people change problem behaviors
- Reduces substance use
  - e.g. Smedslund G, Berg RC, Hammerstrom KT, et al. Motivational interviewing for substance abuse. 2011. Cochrane Database Syst Rev.
- Basic communication style
  - **O**pen questions that encourage further elaboration and consideration
  - **A**ffirmations that foster positive feeling in the consultation
  - **R**eflections that indicate that the clinician has heard and accurately understood the patient
  - **S**ummaries that extend the basic reflections to include a sense of momentum or build interest in changing direction

Case: Malcolm

- ID: 69 year old single male with no children, originally from the UK
- Homeless after leaving his Scarborough apartment for 10 days because he felt unsafe with crack dealers knocking on his door
- Sustained a non-traumatic insufficiency fracture of the hip which was managed conservatively in acute care before transfer to rehab
- Referred to geriatric psychiatry for suicidal ideation

Psychiatric presentation

- Depressed mood, decreased appetite, anhedonia, insomnia, anergia, feelings of guilt, hopelessness
- History of PTSD from childhood physical, emotional, sexual abuse while in institutional care but no active intrusive symptoms
- No mania or psychosis
- Extensive previous psychiatric hospitalizations
- Forensic history: 20+ years in various federal penitentiaries for charges including armed robbery, aggravated assault.
- Medical history: multiple head injuries in fights (no hospitalization), CAD, MI, COPD
- Family psychiatric history: Mother severe depression - institutionalized

Suicide assessment

- Fleeting thoughts of suicide in moments of severe distress e.g. thinking of jumping out of his hospital window or walking into traffic
  - No concrete plan
- Chronic history of suicidal thoughts but they were acutely increased now
- Longstanding history of depression and PTSD
- History of serious suicide attempts including an attempted hanging 3 years ago that resulted in an 8 day psychiatric hospitalization
- Detailed inquiry revealed that the acute stressor was that he felt himself in a **predicament** because he did not want to return to his apartment

Suicide assessment

- Risk factors: Age, gender, psychiatric illness, trauma, substance use, immigration, chronic pain, history of impulsive behavior, isolation, lack of social support, hopelessness
- Protective factors: Engaged well, no immediate access to means, some degree of future orientation, contracted for safety, increased supervision and assessment available in hospital

Substance use

- Cocaine – onset mid 30s, peak use at 55 years old – 3-4 grams per month, last use (crack) 15 days earlier
- Cannabis – daily, 4 grams per week in joints, continued use in hospital
- Opioids – history of IV heroin, abstinent from illicit use for 19 years
  - Currently on oral opioids for pain due to hip fracture
- Alcohol – 5-8 standard drinks daily since adolescence, periods of abstinence up to 3 months before relapsing, last use two weeks ago
- Tobacco – current smoker, 1-2 ppd since adolescence
- He would like to be abstinent from all substances except cannabis

Diagnosis and management

- MDD, PTSD (complex, chronic), cocaine use disorder (moderate), opioid use disorder (in remission but treated with opioids in hospital), alcohol use disorder (moderate)
- Mild neurocognitive disorder due to multiple etiologies (TBIs, EtOH, possible OSA) vs. AD
  - MoCA 21/30 (-1 cube, -1 clock, -1 attention, -1 repetition, -5 recall, -1 orientation, + 1 education grade 10, memory index score 7/15)
- MDT allayed his concerns about discharge to apartment
- Treatment of depression and PTSD with SSRI, bupropion
- Gabapentin for pain and EtOH cravings
- Move to LTCF – activities, comradery with co-residents and staff
- Sleep study – severe OSA – refuses CPAP
- Weekly follow up in group cognitive therapy for addictions

One year follow up

- Mood stable
- Occasional fleeting thoughts of death, no suicide attempts or deliberate self harm
- One relapse of EtOH leading to a week in jail and then one relapse with crack; quit smoking
- Attends almost all CTAG sessions and is a valued member of the group
- Feels a sense of community in his LTCF and a sense of purpose in the group

COVID-19

- LTCF on lockdown – confined to room, no groups at LTCF
- Increased depressive symptoms and insomnia
- Increased flashbacks of trauma, rumination on family
- Continued CTAG group virtually

Resources

Toronto Central Healthline list (Psychogeriatric clinics):
https://www.torontocentralhealthline.ca/listservices.aspx?id=10234

CMHA – Help for Seniors list:
https://toronto.cmha.ca/help-for-seniors/

Sinai Health list (Psychogeriatric clinics):
https://www.mountsinai.on.ca/care/psych/patient-programs/geriatric-psychiatry/prc-dementia-resources-for-primary-care/community-resources-and-directories/outpt-psychogeriatric-clinics-directory-may.pdf

UHN – Substance Use and Addiction Resources:
https://www.uhn.ca/PatientsFamilies/Health_Information/Health_Topics/Documents/Resources_for_Addictions.pdf

Crisis Services Canada – Suicide Prevention and Support
https://www.crisisservicescanada.ca/en/ - local crisis lines and distress centres
1-833-456-4566 (24/7/365); text 45645 (4pm-12am)

Metaphi: Mentoring, Education, and Clinical Tools for Addiction.
http://www.metaphi.ca/

Resources (OTN) – Mental Health and Addictions

Virtual Care for Mental Health & Addictions During the COVID-19 Pandemic

Accessible Directly by Patients

Togetherall

togetherall

Online peer support and self-management tool for people experiencing symptoms of mild to moderate depression and anxiety.

Increase in activity during the pandemic in Ontario (Jan & Feb vs. Mar & Apr 2020)

- ↑120% Member Registrations
- ↑81% Member Engagement
- ↑54% Member Logins

Registration – Free for Ontarians

togetherall.com

For Youth 16+ and Adults – Available in English

iCBT

beacon MORNEAU SHEPELL

Internet-based cognitive behavioral therapy (iCBT) to address symptoms of mild to moderate anxiety and depression.

Available for frontline health care workers and the public, as well as at:

- 9 Campuses: College and University
- 4 Hospital Hubs: CAMH, Ontario Shores, Waypoint, The Royal

Registration – Free for Ontarians

AbilitiCBT | MindBeacon

For Youth 16+ and Adults – English and French

Ontario Virtual Care Clinic

Free online service that provides access to a family doctor for non-COVID-19 related issues during the crisis.

Intended for people who don't have a physician or cannot access their own.

Covered by OHIP

SeeTheDoctor.ca

Available in English

Additional Resources

BounceBack® reclaim your health

Kids Help Phone

WELLNESS TOGETHER Canada | Mental Health and Substance Use Support

Ontario MH&A Support

All Available in English and French

Referral from Provider Required

Clinical MH&A Consults

otn.

Providers registered on the OTNhub can offer virtual MH&A services directly to patients or refer them to someone who can help.

Utilization of direct to patient MH&A Consults via OTNhub (Apr 2019 – Feb 2020)

- 413,573 Visits: From All Users/Orgs
- 70 Orgs: Make up 80% of All Activity

Health Care Organization Registration

Sign-Up Link

Can be Used by English and French Organizations

Child and Youth TeleMental Health

otn.

Telepsychiatry by allied health providers for children, youth, and their families, in remote and rural communities using PCVC OTNInvite.

Patients are to referred by providers to the 3 hubs: SickKids, CHEO, CPRI

- 63 Sites: Providing access to TeleMental Health
- ↑47%: PCVC usage since 2017

Accessing TeleMental Health

Referral Form

Available in English and French

Virtual Care for Substance Use Disorder (also accessible directly by patients)

Solutions that assist with early intervention, prevention, and rehab, using electronic behavior management. Providers can contact the vendors to activate special offers for patients during the pandemic:

- BREAKING FREE™: Free registration until July 31st for 1 year of access
- FeelingBetterNow®: Free usage of the solution for 90-days
- wagon: Online programs & support groups for frontline workers

Learn More and Contact Vendors

For Youth 16+ and Adults – English and French

Breaking Free in Ontario (Apr 17 – May 27, 2020)

- 308 + Patient Activations
- 86% User Retention
- 51% After-Hours Activity

This is a summary of the COVID-19 virtual care offerings that Ontario Health (OTN) is currently supporting. There are other initiatives supported by various MH&A organizations in Ontario. For more information, please email info@otn.ca.

Ontario Health OTN

References

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https://www.amazon.ca/Psychotherapy-Essentials-Motivational-Interviewing-Concurrent-ebook/dp/B00AWDXU66

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Addressing Social Isolation In Older Adults Amidst COVID-19 Pandemic

2020 Toronto Geriatrics Virtual Update Course -OCTOBER 30, 2020

Anna Siciliano, B.A.(Psych), BSW, MSW, RSW

Introduction

Anna Siciliano

Social Worker Care Navigator- *Independence at Home Community Outreach Team*. Providing care navigation services to older adults and caregivers to support independence at home.

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Objectives

1. Understanding the Prevalence of Social Isolation Among Older Adults
2. Screening for Social Isolation and Mitigating Approaches
3. Resources for Building and Strengthening Relationships Amidst COVID-19 Complexities

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Social Isolation and Loneliness-Key Differences

LONELINESS

The way someone *perceives* their situation, one can still feel lonely despite having supportive people in their life

SOCIAL ISOLATION

A lack of social engagement affecting the individual's psychological; cognitive, and medical health well-being

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The Prevalence of Social Isolation

What are the Facts?

According to a study conducted by the *National Senior Counsel*

50% of adults over 80 years of age reported feeling lonely

17% reported feeling excluded

16% reported feeling isolated

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Impacts of Social Isolation

INDIVIDUAL

- Increased prevalence of depression and anxiety
- Decreased social skills
- Impacts to self-esteem, self-confidence, & self- identity
- Negative implications on access to healthcare system
- Negative health behaviours:
  - Substance misuse
  - Falls
  - Inactivity/sedentary lifestyle
  - Poor diet

COMMUNITY

- Stressors on healthcare system
- Visits to the Emergency Departments
- Impacts to social cost
- Increased marginalization
- Risk factor for elder abuse

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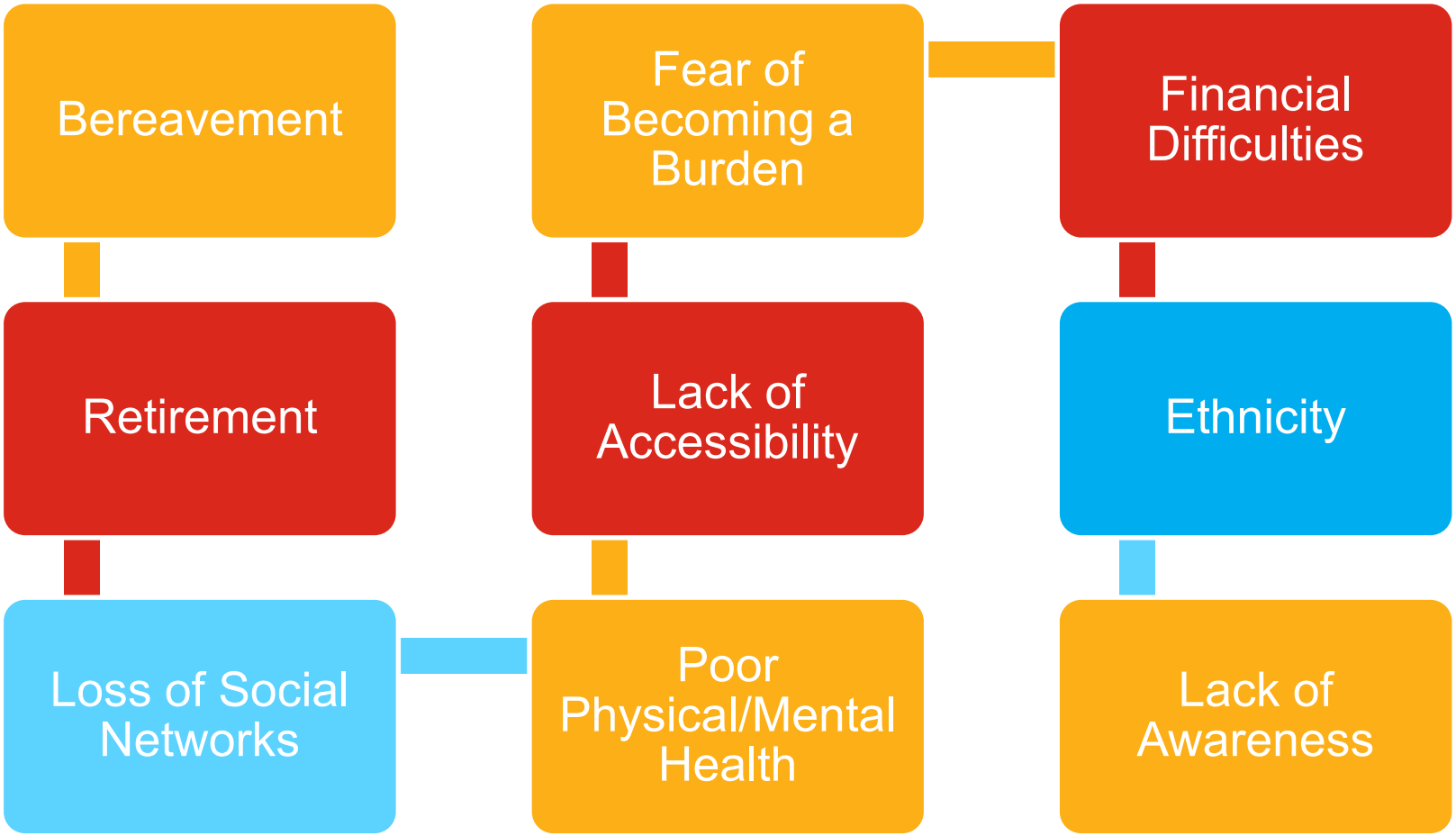
9 Risk Factors to Identify Social Isolation



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Who is at Greater Risk?

- In adapting a client-centered perspective, it is vital to recognize when clients may be at a heightened risk
- The Canadian Government has highlighted who may be further at risk for social isolation

LGBTQ Older Adults

- About 50% of LGBTQ seniors who are not in a marital relationship
- May be living alone
- May not have children
- Feelings of being unwelcomed at seniors programs

Indigenous Older Adults

- Lack of resources in rural communities
- Lack of resources that preserve indigenous culture
- Impact of colonization: Indigenous seniors remain socially disadvantaged (economically, food security etc.)

Recent Immigrants or Refugees

- 63% of immigrant seniors report that they do not speak English
- Challenges with Settlement
- Limited connectedness to community

Substance Use Resources

- **Community Outreach Programs in Addictions (COPA)** https://www.reconnect.on.ca/communityhealthservices
- **The Centre for Addiction and Mental Health (CAMH)** www.camh.ca
- **Metro Addiction Assessment Referral Service (MAARS)** https://www.camh.ca/en/your-care/programs-and-services/metro-addiction-assessment-referral-service-maars
- **ConnexOntario** https://www.connexontario.ca/en-ca
- **Toronto Community Addiction Team (TCAT)**

https://www.sschto.ca/Adults/Addictions/Toronto-Community-Addiction-Team-

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Social Activation at Home

Friendly Visiting Services

In-home volunteer visits

Millenium Support
- (416) 925-4417

The Second Mile Club
- (416) 597-0841

St. Paul's L'Amoureaux Center
- (416) 493-3333

VON- Greater Toronto Area
- 1 (866) 817-8589

Friendly Phone Calls

Phone well-being checks

Circle of Care
- (416) 635-2860

Better Living Health and Community Services
- (416) 447-7244

Baycrest Senior Support Program
- (416) 785- 2500 ext. 2223

North York Senior Center
- (416) 733-4111

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Social Activation in the Community

Adult Day Programs

Supervised programing to older adults

- Circle of Care, Sinai Health System
- Baycrest Health Sciences
- SPRINT Senior Care
- WoodGreen Community Services
- Dixon Hall Neighbourhood Services

Congregate Dining

Socialization with others with provided meals

- Reconnect Community Health Services
- The Second Mile Club
- West Neighborhood House
- Millennium Support

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Resources for Accessibility

Transportation Services

Assisted Transportation

Circle of Care -iRide

- 1-844-474-3301

SPRINT Senior Care

- (416) 481-6411

Harmony Hall for Seniors

- (416) 752-8868

CANES Community Care

- (416) 743-3892
- Toronto Ride

Community Companion

Accompaniment Services

Spectrum

- 1-844-422-7399
- Accompany to events, errands or doctor's appointments

WoodGreen Community Services and Wellness for Seniors

- (416) 572- 3575
- Accompaniment to doctor's appointments

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Lifelong Learning Resources

George Brown College

- 20% Discount for Continuing Education Courses

Toronto District School Board

- Provide Continuing Education and Daytime Workshops to Seniors

Ryerson University

- LIFE Institute

University of Toronto – Later Life Learning

- Non-Profit Educational Program for Retired Seniors

Humber College

- Offer Tuition Discounts for Seniors 65+

Baycrest Health Sciences Technology

- The Technologies for Aging Gracefully Lab in Partnership with University of Toronto

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COVID-19 Considerations

- Virtual Resources –online support groups for clients and caregivers (i.e., Circle of Care, Alzheimer's Society of Toronto)
- *Breezie* Senior Friendly Tablets (www.breezie.com)(IT support/Internet)
- Virtual Falls Prevention and Exercise Classes
- Virtual Counselling
- Phone Pal/Caller Reassurance Programs
- Virtual Adult Day Programs
- Virtual Music Therapy at Baycrest Health Sciences

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Case Study – Mr. P.

DEMOGRAPHICS:

- Mr. P. is an 83-year-old male. Resides alone in a market rental condominium in downtown Toronto
- Very few friends and no familial supports in Toronto. Socially isolated

MEDICAL HEALTH:

- Osteoporosis. Fall in 2018 resulting in a hip fracture. Subsequent admission to an inpatient rehabilitation facility
- During inpatient admission, dementia diagnosis (mild to moderate range with frontal lobe features). Vision impairment -cataract surgery (2017)
- Referral to IAH COT for short-term case management; exploration of resources to assist with ADL and IADL function; linkage to a primary care provider
- Community legal clinic completed a referral to OPGT Guardianship Investigations. In 2019, Mr. P. assessed to be incapable related to management of finances. Assignment of OPGT

PSYCHOSOCIAL & SOCIOECONOMIC PROFILE:

- Prior to COVID-19 pandemic, Mr. P. habitually attended his office located in Toronto that was at one time operational. Regular attendance at the office provided a sense of purpose, stability, social and cognitive stimulation
- Geriatric team Social Worker -linked with office property management office to assist clearing of office for purposes of renting this office space to another tenant

Case Study – Mr. P.

COMMUNITY INTERVENTION:

- In September 2019, IAH COT geriatrician conducted an in-home comprehensive geriatric assessment. Diagnosis of moderate dementia
- Recommendation of referral to TC LHIN --PSW services to assist with personal care; in-home Occupational Therapy assessment and in-home PT to assist with balance and mobility. All interventions declined by Mr. P.

COVID-19 IMPLICATIONS:

- Amidst the COVID-19 pandemic, Mr. P's social isolation has significantly increased. He voiced suicidal ideations. In August 2020, Toronto office permanently closed due to significant rental arrears
- Mr. P.'s mobility has significantly declined and venturing out independently in the community to access his bank and groceries has been problematic

Case Study – Mr. P.

INTERVENTION PLAN:

- Geriatric team Social Worker –weekly groceries through Friendly Neighbor Hotline. Grocery receipts are forwarded to OPGT. In September 2020, Mr. P. accepted MOW services
- Mr. P. connected to Caller Reassurance Program to provide telephone wellness checks
- Geriatric team Social Worker has maintained weekly telephone contact, including face-to-face visits for purposes of providing well-being checks; social and cognitive stimulation
- Linked Mr. P. to SMH/BRIDGES program for homebound primary care; Dixon Hall Neighbourhood Services for Social Work case management (transfer meeting conducted); Toronto Ride transportation services; Friendly Neighbour Hotline/UHN for weekly grocery deliveries
- TC LHIN funded PSW services were trialed for a brief period to assist with personal care, laundry and light household tasks which were eventually cancelled by Mr. P. A TC LHIN in-home OT referral was also completed which Mr. P. declined

Resources

- **Toronto Seniors Helpline** - Information, referral & navigation of resources for frail older adults (including, neurocognitive disorders) and crisis support (COSS-Crisis Outreach Service for Seniors) @ 416-217-2077

➢ **torontoseniorshelpline.ca**

- **www.centralhealthline.ca**

- **www.torontocentralhealthline.ca**

- **www.seniors.gc.ca** - Central resource for older adults, families, caregivers, and service organizations. Provides information for older adults on federal, provincial, territorial and some municipal government benefits and services(i.e., finances, housing, health and wellness)

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