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# DUAL DIAGNOSIS IN ONTARIO'S SPECIALTY (PSYCHIATRIC) HOSPITALS: *QUALITATIVE FINDINGS AND RECOMMENDATIONS*

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## *PHASE II SUMMARY REPORT*

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**Dual Diagnosis in Ontario's Specialty (Psychiatric) Hospitals:  
Qualitative Findings and Recommendations**  
*Y. Lunsky and J. Puddicombe*

**EXECUTIVE SUMMARY**

**1. INTRODUCTION**

**This report summarizes findings from Phase II of a study funded by the Ontario Mental Health Foundation on treatment of individuals with a dual diagnosis (developmental disability and psychiatric disorder) in Ontario's specialty hospitals<sup>1</sup>.** The first phase focused on the prevalence of dual diagnosis in the specialty hospital system, and presented an overview of patient demographics, symptom profile, strengths and resources, and level of care required. Findings revealed that individuals with a dual diagnosis had more severe symptoms, fewer resources, and required a higher level of care than other patients served by the hospital system.

The purpose of Phase II was to seek feedback from diverse stakeholder groups across the province in order to: discover whether Phase I findings matched stakeholder observations; identify unique and/or regional issues that could provide a context for Phase I findings; and, to hear recommendations from different viewpoints about how to improve dual diagnosis services across the province, particularly in relation to the role of speciality hospitals.

**METHOD**

Round-table discussions/focus groups and key informant interviews were conducted between November 2004 and February 2005 with staff at Ontario's nine specialty hospitals and their respective community partners located in: 1) Brockville, 2) Hamilton, 3) Kingston, 4) London, 5) North Bay, 6) Penetanguishene, 7) Thunder Bay, 8) Toronto, and 9) Whitby.

**2. KEY FINDINGS**

**LIMITED SPECTRUM OF SERVICES**

Individuals with a dual diagnosis require a variety of mental health services, ranging from standard outpatient services to specialized inpatient care. The majority of these individuals require intensive community and residentially based mental health care, but intensive services are largely unavailable in most communities. Inadequately treated mental health concerns can lead to crises for clients and their families, and increase risk for psychiatric inpatient admissions at the general or specialty hospital.

**INADEQUATE INTER-MINISTERIAL COLLABORATION**

Unlike most other psychiatric populations, individuals with a dual diagnosis obtain their services through two distinct sectors which function very differently: the developmental sector, funded by

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<sup>1</sup> Note: Phase One of this study began when Ontario's tertiary level mental health care hospitals were called "Provincial Psychiatric Hospitals (PPHs)". At the time of the printing of this report, seven former PPHs had divested to other health facilities, and only two hospitals still operate as PPHs. Consequently, all tertiary level mental health care hospitals (former PPHs) are referred to in this report as "specialty hospitals."

the Ministry of Community and Social Services (MCSS) and the mental health sector, funded by the Ministry of Health and Long Term Care (MOH). Guidelines exist with regard to how individuals with a dual diagnosis should receive services from both ministries but these guidelines are unclear in terms of who is eligible for services, and the responsibilities of each sector to provide such services. This lack of clarity results in individuals with a dual diagnosis being denied services from both sectors.

### **SHORTAGE OF APPROPRIATE HOUSING**

As reported in the Phase I study, the average length of stay for patients with a dual diagnosis is over five years, yet many of these individuals could be served in the community if appropriate supports were available. Informants believed that individuals who are ready to be discharged often remain in hospital because there are not enough appropriate residential settings for them. These patients are referred to as “bed blockers” because they no longer require hospitalization, yet they limit new admissions to the hospitals. Consequently, hospital staff become hesitant to admit such patients because of later difficulties they will likely have discharging them.

### **LACK OF KNOWLEDGE, EXPERTISE AND HUMAN RESOURCES**

There is a shortage of clinicians with expertise in the area of dual diagnosis, and a general lack of qualified individuals willing to work with this vulnerable population. In general, developmental disability service providers lack knowledge of mental illness, and mental health service providers lack knowledge of developmental disabilities. Such shortages and limitations make it difficult to provide proper services or to implement recommendations made by specialists, and reduce the quality of care provided. This leads to a general reluctance by providers to serve this population, which increases the client’s risk for mental health crises and hospitalizations.

### **AGGRESSION / CHALLENGING BEHAVIOUR**

Numerous individuals with a dual diagnosis served by the specialty hospitals have problems with aggression. The inability of community providers to safely manage these individuals in the community leads to their hospitalization. Hospitals (unlike community providers) have the option to use physical restraints and seclusion rooms to manage aggression. However, hospital providers typically focus on *management* of aggression rather than on trying to understand its function and ultimately reducing it, making such individuals difficult to discharge back to the community.

## **3. RECOMMENDATIONS**

### **AVAILABILITY OF A FULL SPECTRUM OF DUAL DIAGNOSIS SERVICES**

In order to maintain people in the community whenever possible, to successfully transfer people to and from hospital, and to prevent relapse, clients with a dual diagnosis need to have access to a complete spectrum of treatment levels. Following the recommended Levels of Care typology used in Phase I, we recommend the following:

*Level 1:* Basic mental health and developmental services (e.g., primary health care, safe housing, social support and daytime activities) must be available to all individuals with developmental disabilities.

Level 2: Outpatient community supports and services (including consultation and treatment) for individuals with a dual diagnosis must be accessible across the province.

Level 3: Each region should have more intensive community services (such as specialized ACT teams and crisis services with expertise in dual diagnosis) that can closely follow individuals with a dual diagnosis, and that can respond to crises.

Level 4: For high need individuals with a dual diagnosis, interdisciplinary homes (sometimes referred to as residential treatment facilities) are required in the community. These are a step down from specialty hospital inpatient units, yet provide mental health and developmental supports in a safe setting.

Level 5: Inpatient services in specialty hospitals must be able to provide interdisciplinary assessment and treatment by clinicians with expertise in dual diagnosis.

### **TRAINING/EDUCATION AND EXPERTISE IN DUAL DIAGNOSIS**

In both the hospital and the community, increased staffing is required, with the following professions being a priority: psychiatrists (with expertise in dual diagnosis); psychologists/psychological associates; behaviour therapists; and, community psychiatric nurses.

Training in dual diagnosis is needed for all staff in both the community and the hospital, including psychiatrists, psychologists/psychological associates, family doctors, nurses, allied health professionals, and developmental service workers. Curriculum on dual diagnosis should be included at the earliest possible level of education of these professions. Priority topics for all groups include: understanding the biopsychosocial model of assessment and treatment, the use (and misuse) of psychotropic medications, and handling and preventing aggression.

### **INTER-MINISTERIAL COOPERATION / PARTNERSHIP**

Partnerships: Partnership between the two ministries is a precursor to partnerships between developmental and mental health agencies. It is essential that joint responsibilities for those with a dual diagnosis remain a priority, that linkages between service systems be established, and that joint initiatives be developed.

Funding: Increased funding by both ministries is required in order to ensure a full continuum of services, resources, staffing, and training. In addition, the ministries need to jointly develop more flexible funding strategies so that services can flow seamlessly between providers.

Guidelines: The two ministries must revisit and clarify the inter-ministerial dual diagnosis guidelines, responsibilities, eligibility requirements, and definitions so that there is an unambiguous and shared understanding across sectors about relevant issues.

## **4. THE ROLE OF THE SPECIALTY HOSPITAL**

Hospitals need to develop better partnerships with community services, and each hospital needs to forge stronger linkages between their specialized outpatient and inpatient programs. Other hospital programs also need to be able to access and to work effectively with dual diagnosis programs. Such collaborations would benefit clients and their families by allowing for smoother transitions between services. In addition, because of the specialty hospital's linkage to research and the province's academic health science centers, these hospitals should play a lead role in terms of dual diagnosis research and education/training.



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**PHASE II SUMMARY REPORT**

**1. INTRODUCTION**

Adults with developmental disabilities are three to four times more likely to have a mental illness compared to other adults. The presence of diagnoses of both a developmental disability and a mental illness in the same person is referred to as a “dual diagnosis.” Individuals with a dual diagnosis have very complex needs and are particularly challenging to serve in the mental health system. Some of these individuals receive their care from specialized programs within Ontario’s former Provincial Psychiatric Hospitals (PPH) because they cannot manage with the minimal psychiatric support provided to them in the community. Unfortunately, once they enter the PPH system, little is known about how to best help them, as most services in the hospitals were not designed with dual diagnosis in mind.

In 1999, the Ministry of Health published the “*Making it Happen*” document, a guide to mental health reform in Ontario. In response to these guidelines, the psychiatric hospitals chose to evaluate their programs in order to learn more about what they could do to help their patients return to community settings with appropriate support in the years to come. This evaluation (known as the CAPS project or Comprehensive Assessment Project) was completed between 1999 and 2003 for the nine Provincial Psychiatric Hospitals in Ontario. The CAPS database now holds information regarding the current situation and the future needs of patients from all of these hospitals.

**This report is a summary of findings from Phase II of a two-Phase study on dual diagnosis in Ontario’s specialty hospitals<sup>2</sup>.** The first phase of this study looked more closely within the CAPS database at the subgroup of patients with a dual diagnosis. The Phase I report summarized findings on the prevalence of dual diagnosis, and presented an overview of patient demographics, symptom profile, strengths and resources, and Recommended Level of Care of individuals with a dual diagnosis by patient status (inpatient/outpatient/homes for special care) and according to whether an individual was served in a dual diagnosis program or a generic program. It also compared individuals with a dual diagnosis to other patients served by the hospital system<sup>3</sup>.

This project has been guided by an advisory group made up of representatives from the specialty hospitals, the Ministry of Health and Long Term Care (MOHLTC) and the Ministry of Community and Social Services (MCSS), community mental health and developmental disability

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<sup>3</sup> For full report of Phase I findings, see: [http://www.camh.net/pdf/dualdiagnosis\\_provpsychhosp\\_1styr2003.pdf](http://www.camh.net/pdf/dualdiagnosis_provpsychhosp_1styr2003.pdf)

service providers, and family representatives (see Appendix C). It is funded by the Ontario Mental Health Foundation.

### **Recommended Level of Care**

As was described more fully in the Phase I report, a Level of Care template is a systematic approach for matching an individual’s needs to a particular Level of Care. General descriptions of the Levels are provided below:

<i>Level 1:</i>	Self management with intermittent use of core community services and supports.
<i>Level 2:</i>	Individualized support on a weekly basis. Psychiatric care provided through regular contact with a psychiatrist or mental health nurse in an outpatient setting.
<i>Level 3:</i>	Community living with intensive integrated treatment and support (daily with 24 hour access). Usually associated with Assertive Community Treatment.
<i>Level 4:</i>	Residential treatment with a strong rehabilitation component. This level is appropriate for persons whose behaviours make it difficult to live independently and at times need a secure environment.
<i>Level 5:</i>	Tertiary inpatient care.

### **The most important key findings from Phase I of the study were:**

- 1 in 8 patients served by the speciality hospitals has a dual diagnosis.
- 1 in 5 inpatients has a dual diagnosis and 37% of these inpatients have been in hospital for 5 or more years.
- 20% of those with a dual diagnosis are being served in specialized dual diagnosis programs; 80% are being served in non-dual diagnosis programs (e.g. Schizophrenia, Geriatrics, etc).
- The dual diagnosis patient subgroup has more severe symptoms, fewer personal and social resources and requires a higher Level of Care than other patients served by the psychiatric hospital system. In particular, patients with a dual diagnosis require more Level 3 and 4 care, and less Level 1 and 2 care, compared to other patients, who require more Level 1 and 2 services, and less Level 3 and 4 services. Interestingly, the need for tertiary level inpatient care (Level 5) did not differ significantly between groups.

## **2. PHASE II**

The purpose of Phase II of the study was to find out from diverse stakeholder groups across the province what concerns and issues were most important in each region of the province. Specifically, we wanted to get feedback on whether Phase I findings matched stakeholder observations, to identify unique and/or regional issues that could provide a context for Phase I

findings, and to hear recommendations from different viewpoints about how to improve dual diagnosis services across the province, particularly in relation to the role of speciality hospitals.

## 2.1 METHOD

Round-table discussions/focus groups and key informant interviews were conducted between November 2004 and February 2005 with staff at Ontario's nine specialty hospitals and their respective community partners located in: 1) Brockville, 2) Hamilton, 3) Kingston, 4) London, 5) North Bay, 6) Penetanguishene, 7) Thunder Bay, 8) Toronto, and 9) Whitby.

At each site, the first author (Dr. Lunskey) gave an hour-long presentation on Phase I findings. Following this presentation, group discussions and key informant interviews were conducted by the two authors. At each location, one author led discussions and took occasional notes, while the other primarily took detailed notes. All conversations were also audio-recorded. For all focus groups and interviews, after brief introductions and a preamble (e.g., "*Based on the findings discussed during Dr. Lunskey's presentation, please provide us with context for these findings, as they relate to your region,*") the following questions were posed:

- 1) "What are the key issues for your region regarding services for those with a dual diagnosis?"
- 2) "What would you like to see changed in terms of services for those with a dual diagnosis?"
- 3) "What role should tertiary level hospitals play?"

## 2.2 PARTICIPANTS

Focus groups and individual interviews were conducted with numerous local stakeholders, including: policy makers, family members, hospital clinicians and administrators, as well as clinicians and administrators from both the developmental and mental health sectors. More specifically, the following groups were present:

- Representatives from the Ministry of Health and Long Term Care (at 5 sites);
- Representatives from the Ministry of Community and Social Services (at 7 sites);
- Parents (at 6 sites);
- Hospital staff, including middle or senior management (at 9 sites);
- Community service-providers (at 9 sites).

**Number of participants in each focus group discussion:** Brockville: 19; Hamilton: 15; Kingston: 18; London: 7; North Bay: 15; Penetanguishene: 17; Thunder Bay: 15; Toronto: 13; Whitby: 17 . Total across all sites = 136 focus group participants.

**Numbers of key informant interviews at each site:** Brockville: 6; Hamilton: 1; Kingston: 4; London: 4; North Bay: 4; Penetanguishene: 6; Thunder Bay: 4; Toronto: 5; Whitby: 1. Total across all sites = 35 key informants.

**Total number of participants:** 156 participants (Some individuals were both focus group participants and key informants, but were not counted twice in the grand total.)

## 2.3 DATA SYNTHESIS

The hand-written notes that were taken by both researchers during the interviews and group discussions were entered into a computer (Microsoft Word file), with the note-taker expanding upon points to add context and detail. Discussions were held between note-takers to broaden the notes as much as possible. For each site, focus group and interview notes were merged, resulting in one file per site.

Audio-recordings of interviews and group discussions were not transcribed verbatim. However, to assess the quality of the data, audio files from two sites were listened to by a person other than the original note-taker in order to make sure that the notes entered onto the computer were complete, that quotations were accurate, and that the content of the notes did not reflect the biases of the note taker. The notes from the two selected sites were considered to be an accurate representation of the audio-recorded discussion, thus it was not deemed necessary to review all audio files. Portions of other files were reviewed in order to obtain quotes.

Through repeated readings of a site's notes and through discussions between research team members, themes and sub-themes relating to the three research questions (key issues, desired changes, role of specialty hospital) were derived. This process was repeated for each site. After this stage was completed, it was discovered that the sub-themes which emerged across all sites were nearly identical. As a result, the authors decided to merge the information from all sites for the purposes of this report. Consequently, themes are not reported on a site by site basis. However, relevant themes which remained unique to a specific site have been kept separate and are highlighted in the report when appropriate.

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## **3. SUMMARY OF THEMES**

The following sections convey some of the major themes that were heard across all sites when stakeholders were asked "What are the key issues for your region regarding services for those with a dual diagnosis?" The major themes include several related sub-themes. All quotations represent statements made by actual stakeholders during the discussions.

Major themes are divided into an "Issue – Consequences" pairing. It is important to note that the issues and consequences listed below are not mutually exclusive. In fact, *all issues and consequences are inter-related and also cumulative*. In addition, many "consequences" are "issues" in and of themselves. However, in the interest of minimizing repetition, this report will not list the same consequences over and over for each issue, nor will it attempt to provide an exhaustive list of issue-consequence combinations.

All descriptions of issues and consequences made below represent the opinions of stakeholders and do not necessarily reflect the views of the authors. Once again, for brevity's sake, we will not qualify each statement with the words "stakeholders believe that..." or "participants noted that..." but will simply directly summarize the issues and consequences.

### 3.1 SERVICE CONTINUUM: LACK OF COMPLETE ARRAY OF TREATMENT LEVELS

Quote: “Right now there is the psych hospital and the ACL with nothing in between.”

*Issue:* By definition, the developmental sector cannot on its own provide Levels 2-5 supports<sup>4</sup> to its clients. Mental health services, according to the joint ministerial guidelines, are the responsibility of the mental health sector. The types of services required most (according to the Phase I study) by the population with a dual diagnosis (e.g. Level 3: 42%, Level 4: 28%), are not available through either sector. Community agencies in the developmental sector do not have mental health crisis beds for their clients, and existing crisis beds in the mental health sector are usually not appropriate. The developmental sector can not address dual diagnosis issues alone, but the mental health sector does not have Level 4 supports either, and many regions do not have Level 3 supports (including ACT teams) that serve this population.

*Consequences:* Great agencies get burnt out because intensive community mental health supports are not in place. Services function in crisis mode because of this lack of support. When clients need something more resource intensive than Level 2 supports, burnt out families and service-providers often seek inpatient admission at the general or specialty hospital (Level 5).

### 3.2 MINISTRY-RELATED ISSUES

Unlike most other psychiatric populations, individuals with a dual diagnosis obtain their services through two distinct sectors: the developmental sector, funded by the Ministry of Community and Social Services (MCSS) and the mental health sector, funded by the Ministry of Health and Long Term Care (MOH). These two ministries have totally separate budgets, planning processes, regulations, philosophies, service delivery structures, and serve different, yet overlapping geographical districts in some parts of the province.

In July of 1997, the two ministries jointly released the document "*Policy Guideline: the Provision of Services for Persons with a Dual Diagnosis.*" This document outlined the specific responsibilities of each sector for this population and was meant to serve as a guide for service providers on how the two sectors should jointly serve this complex population.

#### **Issue: Eligibility criteria are unclear**

Government policy and guidelines regarding dual diagnosis are unclear. Part of the lack of clarity lies in the definitions themselves, which are being interpreted differently by different people. Many questions remain unclear to stakeholders, such as:

- If someone with a developmental disability has a serious behaviour problem, does this constitute a dual diagnosis or must they also have an Axis I or Axis II disorder?

<sup>4</sup> For description of Levels, see page 6.

- Does having a dual diagnosis *without* a comorbid diagnosis of “serious mental illness” qualify a person for mental health services for people with “serious mental illness”?
- If a person has an autistic spectrum disorder but an IQ in the borderline range, do they qualify for dual diagnosis services?
- If a person meets criteria for developmental disability currently, but their age of onset was after age 18, do they qualify for dual diagnosis services?

Consequences: The guidelines are not being interpreted correctly, nor adopted properly in many areas. Thus, in many parts of province, clients who should be eligible for services are not able to access them.

**Issue: Individuals with a dual diagnosis are being denied services**

Quote: “*Each sector thinks the other sector has all the answers.*”

Despite the joint ministry guidelines clearly stating that it is the responsibility of community and hospital based mental health programs to provide mental health services to those with a dual diagnosis, these agencies are not accepting individuals with a developmental disability. Instead, the mental health sector says “dual diagnosis is not a mental health issue” and denies services, thinking that dual diagnosis clients would be better served by the developmental sector. Similarly, the developmental sector cannot deal with mental health issues and refers clients back to the mental health sector. Neither sector will take responsibility for providing services to those with dual diagnosis.

Consequences:

Quote: “[*Clients*] ping pong between two sectors”

Clients fall through the cracks. Those with a dual diagnosis are getting referred back and forth between systems, and receive little service from either.

**Issue: Lack of ongoing planning**

Following the 1997 release of the joint-ministry document "*Policy Guideline: the Provision of Services for Persons with a Dual Diagnosis*", the two Ministries jointly released a companion document in June of 1998, entitled "*Dual Diagnosis Policy Guidelines Implementation Workplan*". The Workplan described expected outcomes, target dates, and responsibilities of the two sectors in implementing the 1997 guidelines.

In many regions, proposed plans developed in accordance with 1998 Implementation Workplan document have yet to be implemented. In some parts of the province, the groups who developed plans have disbanded and there has been no follow-up activity.

Consequences: There is not enough inter-ministerial planning occurring presently which includes hospital and community in both sectors. The planning that is taking place is not standardized across the province and communication between regions is limited. Without the appropriate infrastructure, it is an ongoing challenge to keep these interministerial groups active.

**Issue: No movement of funds between Sectors**

*“There are silos in our communities that we need to break down”*

Due to Ministry silos, once a client is receiving services from one sector, they cannot easily use such funds to access services from “the other” sector. In the community, there is no lateral way to transfer funds from one agency to another (e.g., from a community mental health agency to a developmental agency) without hospital admissions in the middle. Clients can not switch or modify their services and keep their allocated funds to do so.

Consequences: Generally, there is no ease of movement between required services for clients because money is tied to one sector or other. This prevents service providers from developing individualized comprehensive service packages that combine expertise from both sectors. These systemic barriers also prevent clients from making smooth and supported transitions. For example, when a client is in hospital, there are no funds allocated to staff in the developmental sector to help facilitate the transition back to developmental services.

**Issue: Closure of the Remaining Institutions**

The current system lacks the capacity to treat individuals being discharged from the remaining three MCSS Schedule One facilities (Hurononia, Southwestern Regional Centre, and Rideau Regional Centre), which are slated to close by 2009. Except for their less extensive mental health supports, the three facilities currently function like a Level 4 to 5 setting due to their higher staff ratio, training of staff including nursing, and regulations on the management of aggression. Stakeholders expressed concern that there are insufficient community resources to deal with the pending 1000 discharges following the closure of these facilities.

Consequences: Without adequate supports in the community, many of the complex individuals will end up requiring the services of the specialty hospitals, which, at this point, are operating beyond capacity and not equipped to deal with a large influx of new patients.

### **3.3 SHORTAGE OF APPROPRIATE HOUSING**

Quote: *“The hospital is not a place for people to live.”*

**Issue: The average length of stay for inpatients with a dual diagnosis is over five years**

A significant number of hospital beds across Ontario are filled with people who no longer require hospitalization and are ready to be discharged, but there are just not enough appropriate residential settings for them.

Quote: *“The developmental sector group homes say that they can’t support the client. So we try to pull in mental health supports but the group home still doesn’t want them. But these individuals are too vulnerable to be in standard mental health group or boarding homes.”*

Even with treatment and support, many clients with a dual diagnosis will never be able to live independently, and thus will always require supportive housing. Available mental health beds (boarding homes, domiciliary hostels, shelters) do not offer enough support. There is a 10 year waitlist for a residential bed within the developmental sector. Hospitals do not know what to do with the population, so they stay in hospital. Stakeholders refer to these patients as “bed blockers”, because of their unnecessarily long admissions.

**Consequences:**

Quote: *“Our hospital has dual diagnosis patients with nowhere to go...  
And no resources to help.”*

- 1) **Institutionalization of clients:** Ironically, once patients have a hospital bed, they become a lower priority for housing in the developmental sector. After long periods in hospital, patients become “institutionalized” and lose some of their community skills, such as preparing meals, traveling, shopping, problem solving, etc. Over time, they also lose the relationships they had in the community. In addition, the longer that patients are in hospital, the more likely they will be seen as less viable for community placement because of their loss of adaptive skills.
- 2) **Backed up system:** The cohort of people stuck in hospital impedes access for new people.

Quote: *“Right now the developmental sector says it can’t get in to [the specialty hospital] and [the specialty hospital] says they can’t get them out!”*

As a result, those who truly require tertiary care cannot access it because the beds are filled. Over time, the hospital learns that admission of patients with a dual diagnosis is unnecessarily lengthy and problematic, so they are increasingly resistant to admitting them. This resistance to admit patients with a dual diagnosis is evident both in tertiary care settings and in local hospitals.

**3.4 LACK OF KNOWLEDGE**

Quote: *“We don’t have the training or expertise to work with them.”*

**Issue: Developmental disability service providers lack knowledge of mental illness and mental health service providers lack knowledge of developmental disabilities**

There is very little dual diagnosis content in psychiatry residency training or in the training of other allied health professionals (e.g., Nursing, Occupational Therapy, Psychology, Social Work). The lack of training is also problematic for direct care staff in residential settings. Clients with a dual diagnosis are living in group homes with staff who have little knowledge of this population.

**Consequences:**

- 1) Mental health care providers, primary care providers, and care providers in the developmental sector are reluctant to treat this population.
- 2) If the client's residence (boarding home, nursing home, hostel, group home) has no skilled or trained staff, then there is no one to implement the client's treatment and support recommendations (e.g. made by a behaviour therapist or ACT team). Without the support to implement recommendations, clients who are not "easily managed" risk getting evicted from their housing. Either that, or they get medicated for behaviour because there is a lack of support.

Quote: "We know we overuse medications, but behavioural interventions are not available"

- 3) The community has difficulty dealing with dual diagnosis clients without basic outpatient support and becomes reluctant to treat or house them.
- 4) When the community gives up, *individuals with a dual diagnosis end up in crisis, and may ultimately be placed in the specialty hospital.*

### **3.5 SHORTAGE OF EXPERTISE**

**Issue: There is insufficient expertise in dual diagnosis**

In addition to the general 'lack of knowledge and training' problem described above, there is a desperate shortage of dual diagnosis specific expertise across disciplines (e.g. psychiatrists, psychologists/psychological associates, behaviour therapists, nursing) in hospitals and in the community.

**Consequences:**

- 1) Patients with a dual diagnosis are often not receiving proper assessment and diagnosis. For example, individuals with developmental disabilities who are aggressive or who have emotional and behaviour problems are getting misdiagnosed as psychotic.
- 2) Patients with a dual diagnosis are often not receiving proper treatment: Patients are not receiving psychological and social aspects of intervention because of the lack of expertise available, and are often over-medicated or improperly medicated. For example, anti-psychotics are over-prescribed and not well monitored. Medication side effects, such as akathisia or chronic constipation, are often missed or are misinterpreted as signs of a

“behaviour or psychiatric disorder,” leading to even more medication and/or behaviour management.

### 3.6 SHORTAGE OF HUMAN RESOURCES

Quote: *“There are just not enough people doing the work.”*

#### **Issue: There is a significant shortage of qualified staff**

Across Ontario, there is a shortage of interdisciplinary resources both in hospitals and in the community. In addition to psychiatry and nursing, clients with a dual diagnosis need psychologists/psychological associates, behaviour therapists, nurses, social workers, speech therapists, and occupational therapists, and they require a cohesive team approach. However, the reality in hospital is that few services are available outside of psychiatry and nursing, and even these professions have problems filling positions, particularly in dual diagnosis.

Quote: *“These folks really require intensive management... and we don’t have the resources.”*

**Consequences:** There are problems with recruitment and retainment of qualified staff in hospitals and in the community. Community agencies are feeling stretched. Service providers cannot take on more clients without more resources and are forced to hire underqualified candidates due to low wages. Hospitals and community service providers are understaffed, with a high burnout rate and increasing turnover in direct care staff. This turnover leads to a lack of consistency in client care and a constant loss of support to clients.

### 3.7 AGGRESSION / CHALLENGING BEHAVIOUR

Quote: *“Aggression is the main ticket into hospital and the main barrier to getting out.”*

#### **Issue: Clients with aggression cannot be safely managed in the community and end up in hospital**

There are a number of individuals with a dual diagnosis who display aggression, either physical or verbal. While not common in all individuals with a dual diagnosis, aggression does tend to be the primary reason for referral to hospital-based services from the community. Aggression is hard to manage both in the community and in hospital. In the community, however, there are a number of barriers that prevent staff from managing aggression safely:

- 1) Lack of training for direct care staff on how to handle aggression and how to prevent it.
- 2) Government guidelines on how aggression should be managed in the community: Community staff reported that, because of these sometimes difficult to interpret guidelines, they have limited options to deal with aggressive clients - They cannot contain a person in a locked

room, they cannot use mechanical or physical restraints, and they only have limited access to chemical restraints. “Crisis Prevention Intervention” is the only form of physical intervention recognized or endorsed within the developmental sector to deal with aggression in the community, and providers have said that it is *not enough*.

- 3) Inadequate staff support, including low staff-to-client ratios. Managing aggression requires increased staff presence, and there are often no staff members to spare when a crisis arises in the community.
- 4) Limited access to specialized clinical services in the community: There is such a long waitlist for services that by the time appropriate services become available, the aggression has become so severe that family or staff are completely burnt out and can no longer continue supporting the individual.

Consequences:

Quote: “*Situations go on way too long in the community without any intervention until they escalate into a crisis.*”

The combination of lack of training, few human resources, restrictive policies and limited intervention options in the community results in clients not being managed safely and frequent staff and/or family burnout. Community providers feel as though aggressive clients are an unmanageable threat to staff and other clients. As a result, when their clients get aggressive, community agencies call the police or bring the client to the Emergency Department, and *clients end up hospitalized or in jail*.

**Issue: Aggression does not get treated in hospital**

As noted above in the section on lack of expertise, many hospital programs do not have access to clinicians with expertise in behavioural strategies and dual diagnosis. In these situations, aggression is only *managed* in the hospital with a “medical approach” (e.g., medical interventions to keep that person and others safe in response to the aggressive behaviour), rather than being *treated* with a biopsychosocial approach (e.g. understanding the function of a patient’s aggression and modifying the environment accordingly).

Consequences: Without psychologists/psychological associates or behaviour therapists working as part of interdisciplinary team with patients around aggression issues, hospitals cannot treat aggression, but can only “manage” it. As a result, aggression in hospital patients is not reduced, treatment options gradually become more restrictive in nature, and discharge becomes increasingly unlikely.

**Issue: Large discrepancies between hospital and community practices**

Stakeholders expressed concern over the discrepancy in aggression-management practices between the hospital and the community, and argued that the different models of care make transitions of aggressive clients from hospital to community services quite difficult: When faced with individuals who display aggression to self or others, hospital staff can choose to place the patient in a “locked seclusion” room or in mechanical restraints, or may administer chemical

restraint. In addition, a single hospital staff member can call a code white if needed and get immediate back-up support/assistance from hospital staff. In the community, they do not have these options: an acting out client in a home with one staff person alone is dangerous, and community staff members are not allowed to employ “restraint options” when faced with an aggressive client. Thus, an individual who displays aggression may be safely managed in hospital, but with methods which are not transferable to the community.

Consequences:

Quote: *“Even agencies that are supposed to serve the dually diagnosed are resistant to serve them when there is aggression.”*

Major differences in how aggression can be managed in hospital and in community lead to problems discharging patients from the hospital to the community. Because the community is not set up to deal with clients who display aggression, and cannot offer high enough levels of support to safely manage aggression, community providers are often unwilling to accept patients with a history of aggression being discharged from hospitals. Even when the hospital has treated the aggression, and the patient can be safely discharged, community providers are hesitant to accept clients with a history of aggressive behaviour. As a result, patients end up staying in hospital much longer than is necessary because there is no place for them to go. Furthermore, these patients create a shortage of acute care beds for new patients, which creates a “logjam” in the whole system.

### 3.8 FORENSIC ISSUES

**Issue: The Forensic Mental Health System was not set up to deal with the unique needs of those with developmental disabilities.**

A significant proportion of people with a dual diagnosis are being served in the forensic mental health system. Some patients are in the forensic hospital system because they got charged for small offences related to aggressive behaviour. Others were inappropriately placed in forensic inpatient units, even when they have not been charged by the police, because of their behaviour problems and the perception that they are too difficult to manage in other hospital units.

Consequences:

Quote: *They’re transforming psych hospitals into psych jails.*

Patients with a dual diagnosis are not receiving appropriate treatment in forensic units. In addition, it is even harder to discharge and re-integrate forensic patients into the community than other individuals with a developmental disability. Providers do not want to serve them. As a result, they end up staying in hospital much longer than is necessary.

### 3.9 FAMILY CONCERNS

**Issue: Families are feeling unsupported and uninvolved**

Although families are an essential resource to clinicians in hospital and the community in terms of being able to provide a comprehensive history of the patient and being able to serve as supports, families feel a lack of involvement and inclusiveness in terms of directing care of their family member and in guiding future policy directions.

*Consequences:* Families described feeling burnt out, isolated, and desperate. These feelings are even more intense for families whose child is being treated far away from home. One mother, from a remote part of Northern Ontario spoke about the challenges she experienced supporting her son (currently an inpatient). She was living in a local boarding home near the specialty hospital to be near her son and she felt isolated from her (and his) home community. She said, “*My son has been here over 2 years. He is 20 now. It is a struggle with him being here. We need more resources and support for families, especially when they are so alone.*”

## **4. RECOMMENDATIONS - WHAT NEEDS TO BE CHANGED**

**Introduction:** The previous sections provided a summary of the most pertinent issues raised by focus group and interview participants regarding services for those with a dual diagnosis. The following sections will outline our key recommendations based on stakeholder responses to the question: “*What would you like to see changed in terms of services for those with a dual diagnosis?*”

### **4.1 LEVELS OF CARE**

Patients with a dual diagnosis need extended treatment capacity, which for some may include a 24-hour system of combined developmental and mental health supports. To have this, there needs to be a better range of services, fewer barriers to these services, and an increased capacity to move people through this range of supports.

Clients can reside in homes served by either the developmental sector or the mental health sector, provided they have sufficient supports (e.g. ACT team) through either or both sectors. In thinking about the following recommendations, it is important to remember that the goal of any intervention should be to keep people in the community whenever possible.

Quote: “*His quality of life could be much greater in a home-like setting.*”

In the community, clients can live in a *home-like setting*. At first glance, treatment in the community may not appear to be cost effective for individuals with a dual diagnosis; even with optimal treatment, some individuals will not “get better,” nor require fewer services. However, community placement, when appropriate, enhances an individual’s quality of life, and also allows psychiatric inpatient beds to be available to the people who require them, when they require them. Services can be deemed most effective if a person can be maintained safely and comfortably in the community without repeated disruptive hospital admissions, which are costly on the system and on the individual and his or her caregivers.

In order to maintain people in the community whenever possible, and to successfully transfer people to and from hospital, while also keeping people from relapsing and returning to hospital, clients with a dual diagnosis need to have access to a complete spectrum of treatment levels and have their treatment delivered by qualified and caring professionals. The following sections will provide recommendations for the provision of service to those with a dual diagnosis as they pertain to the Recommended Level of Care template developed for mental health services (as outlined on page 6 of this document and in the Phase I report).

#### **Level 1**

At this Level, individuals are capable of self-management and may attend an outpatient clinic or see a family physician on an occasional basis. They may also intermittently use a range of core community services and supports.

*Quote: People have been managed too long at the specialist level. We need to be more focused on getting people back out of hospital.  
We can't do this without housing and day program services.*

**Recommendations:** If we want to promote mental health in all individuals with developmental disabilities, we must ensure adequate provision of more basic mental health and developmental services. At a minimum, we must provide:

- Social activities and programs;
- Social support;
- Regular case management;
- Meaningful daytime activities (which may or may not have a “vocational” emphasis, depending on the needs of the individual);
- Primary health care; and
- Safe, permanent housing

### **Level 2 – Outpatient Services**

Individuals requiring Level 2 care need individualized support on an ongoing and regular basis (i.e., once per week) and may require assistance in accessing core community supports and services. Their mental health care could be provided through regular contact with a psychiatrist or mental health nurse in an outpatient clinic that is linked to the specialty hospital, or through community based mental health services or a community psychiatrist’s office.

#### ***Recommendation: Facilitate access to outpatient community supports and services***

Although Level 2 care is not typically considered “intensive,” it is more intensive for those with a dual diagnosis than it may be for the general population, where fewer professions are routinely involved. In order to facilitate access to core community supports and services for those with a dual diagnosis, every region in Ontario should have a specialized dual diagnosis outpatient team that can assess, consult, refer, and/or provide treatment to those with a dual diagnosis. The ideal team would take referrals from either the developmental or the mental health sector and would be linked to hospital-based inpatient programs. Currently, the Dual Diagnosis Consultation Teams of Kingston, Ottawa, and Toronto provide similar services (see Appendix A for more information on programs). Note: Not all Level 2 services need to be provided by a specialist team, but such a team is required in certain situations.

#### ***Recommendation: Increase availability of interdisciplinary assessment and treatment***

In order to be properly treated or referred, clients with a dual diagnosis often need to be assessed in a number of areas, including psychiatry, psychosocial & family issues, cognitive ability, adaptive & maladaptive behaviour, nursing & medical concerns, occupational therapy, and speech & language. Preferably, these assessments would be weaved together by a team of experts who have ongoing working relationships with each other. The team communication process is key for this population because, unlike other individuals, many people with developmental disabilities require support in order to understand, retain, and/or communicate information about their treatment with other service providers. When more than one discipline is

involved in a client's treatment, it is important that regular team meetings occur to update other team members on treatment progress.

### **Level 3 – Intensive Outpatient Clinical and Support Services**

Persons requiring this Level of Care are capable of living in the community if they receive intensive, integrated community treatment, rehabilitation and support. They may need daily visits and the availability of 24-hour, 7 days/week clinical services and/or support. This wrap-around service requires lower caseload ratios and is usually associated with a multi-disciplinary team approach such as provided by Intensive Case Management or Assertive Community Treatment (ACT) teams.

**Recommendations:** Each region should provide more intensive outpatient clinical services that can follow clients with high needs more closely than Level 2 services and that can respond to crises. If, for example, ACT teams are used to provide this Level of Care, they could either be specialized dual diagnosis ACT teams, such as the Brockville Assertive Community Treatment Team (ACTT) for Persons Dually Diagnosed, or they could be regular ACT teams who access dual diagnosis expertise through specialized programs, such as the ACT Dual Diagnosis Consultation Service in Toronto (provided jointly by CAMH and Surrey Place Centre).

### **Crisis services**

**Recommendations:** To ensure that hospital services are used appropriately, the community requires a crisis system that can be reliably accessed instead of the hospital (when emergency services are not necessary). To successfully keep people out of hospital, a crisis system would require crisis beds, respite services for caregivers, and additional community outreach services. Mobile crisis teams are a necessity: either specialized such as the Pineview Dual Diagnosis mobile crisis team operating out of the Penetanguishene region, or generic but with links to dual diagnosis expertise, such as the mobile crisis teams participating in the Griffin Community Support Network in Toronto.

Crisis phone lines are also a necessity so that a person with a dual diagnosis in crisis could call and speak to someone who was comfortable and willing to talk to them. Crisis lines are also important for caregivers (family member, case manager, triage nurse in local hospital), who often need immediate information on how to access resources and who best to contact in times of crisis.

In general, a greater emphasis on crisis prevention must occur, including educating caregivers to recognize mental health issues prior to crisis, and providing support and treatment in the client's natural setting when such issues arise.

### **Level 4 - Residential Treatment**

Persons requiring Level 4 care need residential treatment with a strong rehabilitation component. This Level of Care is appropriate for persons who need daily support, whose behaviours make it difficult for them to live independently, and who may at times need a safe environment.

**Recommendations:** Findings from Phase I on recommended Level of Care, combined with feedback from stakeholders, strongly suggests that in order to unblock hospital beds, to help those with a dual diagnosis live successfully in the community and to prevent unnecessary future hospital admissions, we require interdisciplinary homes available in the community which offer Level 4 mental health supports, with a strong developmental component, nursing, 24-hour awake staff, and individualized plans. Level 4 treatment provides an alternative to tertiary inpatient care (Level 5) for those who need a high level of support in a supervised setting, but not the clinical expertise provided in tertiary care settings. Level 4 homes could include nursing and long-term care homes if they had enhanced capacity to deal with individuals who have mental health problems. It might also include smaller, residential settings with clinical staff on site and the capacity to provide security and rehabilitation.

*Re: Institutions closing:* All communities must develop additional sources of intensive supports if they are to have the capacity to provide services to the influx of discharges from the closing institutions.

### **Aggression Management**

There is a clear concern and frustration from stakeholders with the current methods of managing aggression. There are a number of recommendations that could help staff in hospitals and in the community handle aggression more safely:

- 1) Increase training and clinical support for direct care staff on how to handle aggression and how to prevent it.
- 2) Synchronize models of care: If the community has no restraints or seclusion room, then the hospital should minimize their use and seek alternatives. Some hospital units reported that when they removed the option of more intrusive interventions, staff found alternative safe solutions.
- 3) Establish higher staff-to-client ratios.
- 4) Increase access to specialized clinical services in the community.
- 5) Develop a province-wide initiative/commitment to broaden current hospital treatment of aggression in clients with developmental disabilities in order to maximize their potential for community living, and improve their quality of life in and out of hospital.

### **Level 5 – Tertiary Level Inpatient Psychiatric Care**

Individuals receiving Level 5 care have complex, difficult to treat psychiatric conditions that may be complicated by their developmental disabilities and other co-existing disorders (e.g., medical illness, addiction, etc).

**Recommendations:** Those in this Level need care and support from an interdisciplinary team (psychiatry, nursing, psychology, occupational therapy, recreation therapy, social work, and Behavioural Therapy) with high levels of dual diagnosis expertise.

This team should:

- Have the capacity to perform comprehensive assessments in a secure setting.

- Be able to assess, consult, provide treatment, and then discharge appropriately.
- Have strong linkages with outpatient services to allow for smooth transitions.
- Practice and disseminate best practice in assessment and management of challenging behaviour/aggression.

## **5. ADDITIONAL RECOMMENDATIONS**

In addition to recommendations regarding developing a full spectrum of services for individuals with a dual diagnosis, several other recommendations were offered by stakeholders regarding how to improve services for those with a dual diagnosis. Key recommendations are summarized below.

### **5.1 EXPERTISE IN DUAL DIAGNOSIS IN HOSPITAL AND COMMUNITY**

Increased staffing in all areas is required. However, certain professions were identified across all regions as a priority:

- Psychiatrists with expertise in dual diagnosis: to work as part of interdisciplinary specialized teams with inpatients and outpatients who have developmental disabilities.
- Psychologists/Psychological Associates: to get accurate information regarding intellectual functioning and to consult to wards in specialty hospitals who are uncertain as to whether their lower-functioning clients meet criteria for developmental disability services.
- Behaviour therapists in hospital and community: to help transfer client skills from hospital to community and to help reduce and prevent aggression. It is important that these behaviour therapists work jointly with physicians and nurses who are monitoring medical aspects of the individuals, and not in isolation.
- Community psychiatric nurses: particularly because of the high use of medications, psychiatric nurses with experience with developmental disabilities are essential in the community.

*Quote: “There are 7500 people with a dual diagnosis in our catchment area and 50% of them are on medications. Who will teach them and their caregivers about these drugs, side effects, etc? Nurses should be doing this, building skills with knowledge of the person’s needs.”*

### **5.2 TRAINING/EDUCATION**

Training in dual diagnosis is needed for all staff in both the community and the hospital, including psychiatrists, psychologists/psychological associates, family doctors, nurses, allied health professionals, and developmental service workers. Curriculum on dual diagnosis should be included at the earliest possible level of education of these professions.

Although the community and hospital have unique training needs, as do the developmental and mental health sectors, priority topics for all groups include: understanding the biopsychosocial model of assessment and treatment, the use (and misuse) of psychotropic medications, and handling and preventing aggression.

Training in dual diagnosis should also be included as a mandatory part of residency for psychiatrists, and should be discussed within the six month chronic care rotation, given that so many patients with a dual diagnosis are receiving their services in the specialty hospitals (chronic care settings). More case based, hands-on learning would be beneficial to residents.

Quote: “*You can’t feel excited until you follow a patient and you see them get better.*”

For example, trainees could follow a complex patient through the treatment process, and see how various disciplines can work together to bring about permanent change. Through more early and frequent exposure, future clinicians can increase their knowledge of and comfort level with dual diagnosis.

### **Methods of Training**

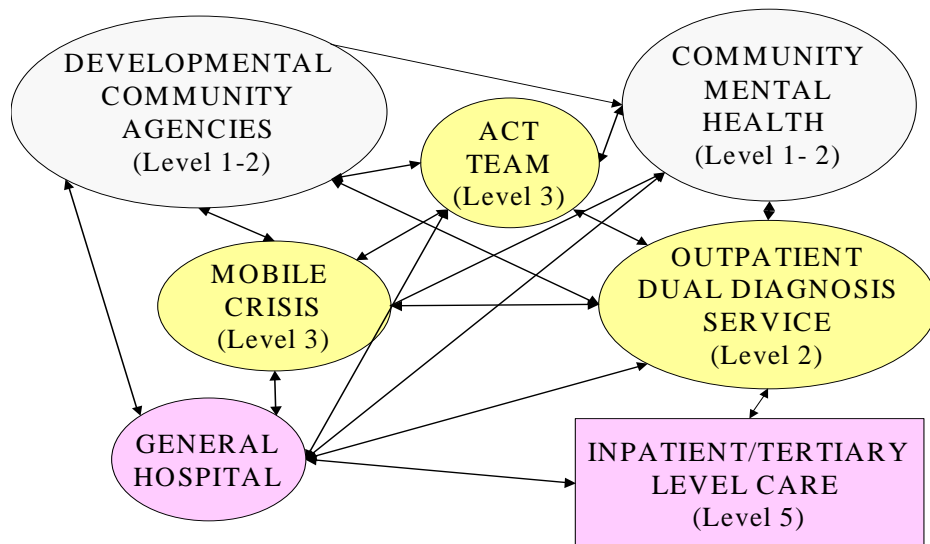
A number of creative training models for current staff were proposed, some of which are already occurring successfully in certain regions:

- **Cross-training through partnerships between agencies:** For example, one agency in the London area provides both community mental health and developmental services through the same community agency so staff can cross-train each other.
- **Use of tele-videoconferencing between hospitals and community dual diagnosis programs.** For example, the current dual diagnosis rounds facilitated by the Royal Ottawa DDCOT team now includes participation from across the province, community agencies and hospitals.
- **Training direct support workers (DSWs) in specialty hospitals as part of their field experience.** For example, one hospital (Penetanguishene) has DSWs working as part of the dual diagnosis inpatient program, which benefits both the unit and the community. Another hospital (London) has DSW student placements on their inpatient dual diagnosis unit.
- **Train-the-trainer training in community mental health agencies through the specialty hospital:** For example, in the North Bay region, a number of undergraduate degree level clinicians are trained in dual diagnosis by the North Bay Psychiatric Hospital’s dual diagnosis program. They are then hired by community mental health agencies across the region who require mental health clinicians with expertise in dual diagnosis, but continue to link with the hospitals’ dual diagnosis program through teleconferencing, team meetings, and regular supervision but at the same time educate the community mental health agency staff on relevant issues.
- **Cross-sector secondments and secondments between hospital and community:** Secondments help to educate staff from various areas about the options and limitations of a given service, environment, or sector. For example, at CAMH in Toronto, a developmental services provider from the community can work as part of the hospital based dual diagnosis team to gain a better understanding of hospital services, and to learn how the team works. In addition, this experience helps the community provider to make more appropriate referrals to the program in the future.

### 5.3 INCREASED LINKAGES/PARTNERSHIPS/COLLABORATION

The majority of individuals with a dual diagnosis require care from more than one service provider, and often these providers are in different sectors. In addition, it is likely that, over time, these individuals will require services at several Levels of Care. The ultimate goal of the following recommendations is for those with a dual diagnosis to have access to a highly fluid system which facilitates seamless transitions between service providers, regardless of which sector they belong to. To reach this goal, several types of linkages and collaboration are required:

**Diagram A: RECOMMENDED LINKAGES**



**Linkages Between All Levels of Treatment:** As illustrated in Diagram A above, all levels of treatment must be linked, for without such linkages one can not use the service continuum fully or appropriately. Developing or strengthening linkages would improve the provision of all services, which would allow for smoother transitions between different types of services, and/or would keep people maintained in their own communities for as long as possible. To prevent duplication of services, formal linkages for sharing what does exist need to be developed. One important way to help facilitate formal linkages is through service agreements.

**Hospital-community partnerships:** Greater flexibility is required so that service providers from either sector can follow the patient while he/she moves between hospital and community based services. Partnerships between hospital and community providers are particularly relevant during the patient’s transition periods into and out of hospital:

*At Admission:* Community-providers must be allowed and be encouraged to play a role in the life of a patient while he/she is in hospital. This is perhaps most important at the time of admission, which can be very traumatic for the patient (e.g., community staff

can work closely with hospital staff prior to and upon admission to help hospital staff become familiar with client), but is also relevant throughout the patient's stay.

***At Discharge:*** Discharge planning should begin at hospital admission and should include community partners. When required, hospital staff should have the flexibility to go into the community to assist the patient to leave the hospital (e.g. the hospitals' behaviour therapist could work with community staff on aggression issues while the patient is in hospital and could also continue doing so during transition to the community.)

**Secondments:** Another way to develop partnerships between and within the sectors is to consider secondments, where a staff member from one service provider or program works for another service provider or program for a time-limited period. Several regions reported that secondments have helped not only to forge linkages but also to familiarize staff with the "culture" of a given setting, which aids future communications/interactions.

**Joint Case Management:** For some cases, it may be appropriate or to the client's advantage if case management can be shared between mental health and developmental service providers, with responsibilities of each clearly defined.

**Linkages Between Professionals and Families:** It would be incomplete to speak about linkages without recommending further linkages between professionals and families.

Parent quote: *"The dual diagnosis is a big issue for children's parents too. Hospitals should use families because it is cost effective and relationship effective."*

Families need to feel encouraged and supported to stay in the life of their children/siblings, particularly in times of crisis, and they need to be involved in decision making as much as possible. It is important to maintain and foster linkages with families, even when other service providers are acting as primary caregivers.

## **5.4 INTER-MINISTERIAL COOPERATION / PARTNERSHIP**

Partnership between the MCSS and the MOH is a precursor to partnerships between developmental and mental health agencies. In several regions, and at the corporate level, meetings between the two sectors are occurring regularly. Some regions have had dual diagnosis committees with joint ministerial participation for some time now with success, and stakeholders in all regions agreed that the continuation of such committees should be a goal/target.

It is essential that joint responsibilities for those with a dual diagnosis remain a priority, that linkages between service systems be established, and that joint initiatives be developed. In addition, further efforts to develop linkages between MCSS, Health, and Corrections must be made to deal with the unique needs of individuals with a dual diagnosis who have legal/forensic concerns.

## **Funding Issues**

*“We need a dual diagnosis funding category that is just missing”*

Increased funding by both ministries is required to ensure a full continuum of services, which includes adequate resources, staffing, and training. In order for services to be more fluid, the ministries need to jointly develop more flexible funding strategies, for example, the bridging of funding allocation – allowing transition of funding from one agency to another even when the two agencies come from different sectors.

## **Guidelines**

In addition to improving funding and collaboration, the two ministries must revisit the inter-ministerial dual diagnosis guidelines, responsibilities, and definitions so that there is an unambiguous and shared understanding across sector about relevant issues, including:

- Who has a dual diagnosis in terms of relevant psychiatric diagnoses (e.g., Axis I or II, serious behaviour problem);
- Which individuals with a dual diagnosis fall under the Serious Mental Illness category outlined by the Ministry of Health;
- IQ cut offs (do services include individuals with borderline IQ);
- When are individuals with Autism Spectrum Disorders (ASD) eligible for dual diagnosis services? (There is a significant subgroup of these individuals with adaptive behaviour deficits similar to those with developmental disabilities, but with slightly higher IQ levels.);
- Age of onset criteria for individuals who currently have IQ below 70 and adaptive behaviour deficits.

## **Planning / Policy: How should change happen?**

There was some debate in focus groups about whether a “bottom up” or “top down” approach would work better in terms of promoting linkages and policy change between ministries. Participants thought that local and regional partnerships were important because such grass roots activities allow change to happen at the local level through the understanding of and familiarity with local idiosyncrasies, and the cultivation of personal relationships. There was also a sense, however, that such bottom up processes should be complemented by top down leadership at the corporate ministry level, such as provincially agreed upon definitions and guidelines with accompanying mechanisms to ensure that guidelines are followed across the province, would allow each region to advocate for and develop certain agreed upon services. Without such action, regional groups complained that they cannot accomplish enough.

## **6. THE ROLE OF THE SPECIALTY HOSPITAL**

Quote: *“If [our] unit functioned the way it is supposed to, we could get the eight people who don’t need to be there out -- We could assess, clarify diagnosis, change medications, and get them back into the community.”*

The final part of each focus group discussion was devoted to answering the question regarding the role that tertiary care should play in the provision of dual diagnosis services in each region. Participants agreed that it was most critical for hospitals to be able to properly offer Level 5 specialized services for dual diagnosis, which include the provision of active treatment and discharge planning, in partnership with community stakeholders.

It is important for hospitals to be very connected to community programs, and to foster strong linkages between their specialized outpatient and inpatient programs, such as is occurring at Whitby, Toronto, Penetanguishene, and Brockville. As well, other (non-dual diagnosis) hospital programs need to be able to access and to work effectively with the dual diagnosis programs.

Other important specialty hospital roles include: playing a lead role in terms of dual diagnosis research and education/training (because specialty hospitals are linked to research and the province’s academic health science centers), and taking a leading role in terms of advocacy for effective partnerships and services.

# **APPENDICES**

## APPENDIX A: PROGRAM DESCRIPTIONS

### BROCKVILLE/OTTAWA – ROYAL OTTAWA HEALTH CARE GROUP

#### **Brockville Psychiatric Hospital - Dual Diagnosis Inpatient Unit**

Established in 1978, the Dual Diagnosis Service is a 29-bed inpatient program that provides intensive assessment and treatment in an environment that is safe and dedicated to the complex needs of patients with both a mental illness and a developmental disability. Some individuals may also have a substance abuse problem, a medical disability, or involvement with the forensic system.

#### **The Treatment Team**

The Dual Diagnosis treatment team is composed of a variety of professionals from several disciplines, including: Psychiatrists; Physicians; Psychometrists; Nurses; Social workers; Vocational counsellors; and Leisure life skills instructors.

#### **Patient Programs**

The Dual Diagnosis unit contains a sun room, a dining room, patient dorms, the Snoezelen (Serenity) Room, and an activity program area, in addition to a fenced yard and therapeutic garden. Patient groups, life skills education and other innovative programs are offered to patients in order to help their transition into community settings and enhance their quality of life. These programs include nutrition education, emotion identification groups, aquatic therapy, and anger management. Patients may also participate in recreational programs and weekly community activities. Patients who are assessed as suitable for vocational work are referred to the Vocational Service program, where they can develop elementary vocational skills and appropriate social behaviour.

#### **Contact:**

MaryLou Macfarlane, Manager  
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Phone: (613) 341-1461, ext. 2300

#### **Brockville Assertive Community Treatment Team (ACTT) for Persons Dually Diagnosed**

The Assertive Community Treatment Team for Persons Dually Diagnosed was established in September 1998, and follows the community based treatment approach used by existing ACT teams. The team is composed of members of several disciplines, including: Physician, psychiatrist, nurses, social workers, behavioural therapists, and a vocational counselor.

The team provides intensive treatment, support, and rehabilitation services to clients in the community, 365 days per year, with evening and weekend services, and 24-hour on-call availability. Services include: symptom management; advocacy; medication monitoring, assessment, and education; long-term clinical relationship; services tailored to meet individual needs; assistance for clients in meeting basic needs/activities of daily living; facilitation of social environment and relationships; support for family relationships; vocational/recreational support;

life-skills teaching; and facilitation of alliances with community and mental health services, including the developmental sector .

**Website:** [http://www.rohcg.on.ca/roh-internet/webpage.cfm?site\\_id=1&org\\_id=1&morg\\_id=0&gsec\\_id=197&parent\\_item\\_id=251&item\\_id=1831](http://www.rohcg.on.ca/roh-internet/webpage.cfm?site_id=1&org_id=1&morg_id=0&gsec_id=197&parent_item_id=251&item_id=1831)

**Contact:**

Assertive Community Treatment Team for Persons Dually Diagnosed  
Brockville Psychiatric Hospital, 10 Oxford Avenue, P. O. Box 1050, Brockville, ON K6V 5W7  
Phone: (613) 498-1492, ext. 2100

**The Dual Diagnosis Consultation Outreach Team (DDCOT)**

Created in November 2001, the Dual Diagnosis Consultation Outreach Team is a multi-disciplinary team located within a specialty psychiatric health care group that serves the mental and physical health needs of dual diagnosed clients within the Eastern Ontario region of Canada. The team consists of an administrative assistant, two registered nurses, an occupational therapist, a psychiatrist, a psychologist, a psychometrist, two social workers, and a speech and language pathologist.

**Contact:**

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320 Catherine street, Ottawa, ON K1R 5T5  
E-mail: [sfarrell@rohcg.on.ca](mailto:sfarrell@rohcg.on.ca)

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**HAMILTON - ST. JOSEPH'S CENTRE FOR MOUNTAIN HEALTH SERVICES  
(formerly: Hamilton Psychiatric Hospital)**

No specialized program for dual diagnosis currently exists.

**Mental Health Rehabilitation Services** is a compilation of services that serve individuals with serious and persistent mental illness utilizing a psychiatric rehabilitation framework

**Mental Health Services for Adults with Developmental Disabilities**

The Centre for Mountain Health Services ensures that patients have access to a seamless range of mental health services that are responsive to individual needs. The partnership includes the Centre for Mountain Health Services, the Area Resource Team of Chedoke-McMaster (Hamilton Health Sciences), and community service providers in the Centre for Mountain Health Services catchment area.

Note: The Chedoke Area Resource Team provides psychiatry, psychiatric nursing psychology, behaviour therapy, speech therapy and language pathology in Brant, Niagara and Hamilton-Wentworth. However, as of Feb 1, 2006, they will no longer be available for consult. A new

team is in the process of being set up called Twin Lakes. This group will have responsibility for all clinical services that are offered to those with dual diagnosis.

**Website:** <http://www.stjosham.on.ca/mentalhealth/adulthandi.htm>

**Contact:**

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**KINGSTON - PROVIDENCE CONTINUING CARE CENTRE (PCCC)**

**The Dual Diagnosis Consultation Outreach Team (DDCOT)**

Launched in 2003, PCCC's Dual Diagnosis Consultation Outreach Team provides assessment, consultation, recommendations, and time-limited treatment for individuals over the age of 16 who have a dual diagnosis - an intellectual disability or autism or pervasive developmental disorder, with a mental or behavioural disorder. The outreach team is an expert resource for primary care physicians, service providers, and caregivers. The team also works to enhance the capacity of service providers through education and training.

The team serves people living in Southeastern Ontario through offices in Brockville, Kingston, and Belleville. Team members include a psychiatrist, social worker, occupational therapist, psychologist, and nurses.

Team members work with the individual, family, service providers, physician and other referral sources to determine a diagnosis and develop treatment recommendations to improve the quality of life of a person living with a dual diagnosis. The individual is assessed in a setting that is familiar and comfortable.

Treatment recommendations may include: education/training and support for care providers and physicians, changes to medication, environmental adaptations to improve function, communication strategies, and advocacy to access services or resources for the client and family.

Recommendations are implemented by the person's physician and primary service providers, with support and consultation from the team. The team provides some time-limited treatment in conjunction with caregivers.

**Website:** <http://www.pccchealth.org/Default.aspx?tabid=125>

**Contact:**

Alexandra Conant, Manager, Dual Diagnosis Consultation Outreach Team  
752 King Street West, Kingston ON, K7L 4X3  
Phone: (613) 530-2400

Email: [conanta@pccchealth.org](mailto:conanta@pccchealth.org)

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## **LONDON - ST. JOSEPH'S HEALTH CARE - REGIONAL MENTAL HEALTH CARE LONDON**

### **Developmental Behavioural Management Program (DBM)**

The DBM unit is an 18-bed active treatment program for individuals between the ages of 18 and 64. We provide multi-modal assessments, person-centered care and a multidisciplinary outpatient clinic on site for individuals with Dual Diagnosis in Southwestern Ontario.

**Website:** <http://www.sjhc.london.on.ca/mhl/programs/dbm1.htm>

### **Contact:**

Pam Roe, Coordinator, Developmental Behavioural Management Program  
Regional Mental Health Care – London, 850 Highbury Ave, Ward S1, London, ON N6A 4H1  
Phone: (519) 455-5110 x47647  
E-mail: [Pam.Roe@sjhc.london.on.ca](mailto:Pam.Roe@sjhc.london.on.ca)

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## **NORTH BAY - NORTH BAY PSYCHIATRIC HOSPITAL (NBPH)**

### **The Regional Specialized Mental Health Program (RSMHP) – Developmental Disabilities Service (DDS)**

Since its inception in 1993, the Developmental Disabilities Service (DDS) of the Regional Specialized Mental Health Program (RSMHP) of the North Bay Psychiatric Hospital (NBPH) has provided psychiatric consultation and ongoing treatment to adults diagnosed with an intellectual disability and serious mental illness residing within the region of Northeastern Ontario on an outpatient basis.

The service's clinical team works collaboratively with community based multidisciplinary teams most commonly located in the client's place of residence. Care is provided from a bio-psychosocial perspective. The provision of psychiatric care is offered on the basis of individual needs, informed consent and/or substitute decision making.

The DDS has established consultative and professional relationships with a number of Associations for Community Living, L'Arche Communities, Christian Horizons support networks and Ministry of Health community based agencies. Partnerships have also been developed with a number of community based interdisciplinary groups providing professional assessment and treatment. The DDS provides psychiatric assessment and treatment through a consultative/liaison model based upon biopsychosocial principles.

**Website:** [http://www.nbpsych.on.ca/NBPH\\_Main/NBPH\\_English/DevDis/index.htm](http://www.nbpsych.on.ca/NBPH_Main/NBPH_English/DevDis/index.htm)

**Contact:**

Garry Fay, Manager, Developmental Disabilities Service  
Regional Specialized Mental Health Program, North Bay Psychiatric Hospital  
Box 3010, 4700 Hwy. 11 N., North Bay, ON, Canada, P1B 8L1  
Phone: 705-494-3176  
E-mail: [Garry.Fay@NBPH.MOH.GOV.ON.CA](mailto:Garry.Fay@NBPH.MOH.GOV.ON.CA)

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**PENETANGUISHENE - MENTAL HEALTH CENTRE PENETANGUISHENE****The Bayview Dual Diagnosis Program**

The Bayview Dual Diagnosis Program (BDDP) is a client-centered specialty care program. The 25-bed inpatient unit offers psychiatric assessment and treatment to individuals with a developmental disability and mental health problems. The program offers a continuum of multidisciplinary team services, including: referral, consultation, inpatient assessment, treatment/stabilization and outpatient community follow-up. To meet the complex needs of the developmentally delayed population, the team members encourage and consider the involvement and cooperation of family, caregivers and physicians essential in providing a supportive network for the client.

**Website:** <http://www.mhcva.on.ca/MHCP/mhcptrtd.htm#bddp>

**Contact:**

Nancy Pilon, Program Coordinator, Bayview Dual Diagnosis Program  
Mental Health Centre, Penetanguishene, Ontario L9M 1G3  
Phone: (705) 549-3181 ext. 2167  
E-Mail: [npilon@mhcp.on.ca](mailto:npilon@mhcp.on.ca)

**Pineview Project****Community Living Huronia - Central East Region (Dual Diagnosis Resource)**

This project has three key components:

- i. Transitional Residential Treatment Home
- ii. Mobile Resource Team
- iii. Developing Community Capacity

**Transitional Treatment Home**

Pineview is a treatment home for five individuals, located on the grounds of the Mental Health Centre Penetanguishene. Operated by Community Living Huronia, the Home provides a short-term treatment program with a maximum time period of 12 months. This allows a multi-disciplinary team with expertise in the area of dual diagnosis to assess, develop and implement a treatment plan for each person based upon their individual needs. Individuals must return to their home community and have supports there to continue the treatment recommendations. Discharge planning will begin with admission to the treatment home, and the home agency maintains case

management and will be actively involved in treatment. Training for agency staff and family is part of the process.

### **Mobile Resource Team**

Assessments will be completed in the individual's home community by the Mobile Resource Team. This will be the only means of access to the five treatment beds. The team will review current supports and current treatment plans and then, using an individualized approach, make recommendations to: (a) remain in the community, perhaps with additional supports required; (b) enter the treatment home; or (c) be hospitalized. Members of the mobile resource team may include a psychiatric nurse, case manager, behaviour therapist, person-centered planner and the transition home coordinator. It is also essential for local supports, along with a small core group from Pineview, to be part of the team.

### **Developing Community Capacity**

There will be an emphasis on building community capacity in each area of the region of identified needs. This will include an emphasis of staff training. Staff training will be done at the transition house for those staff working with individuals in residence there and in the home community. To ensure appropriate co-ordination and continuum of service, it is expected that the home community will be actively involved in ongoing planning and training activities. This will include follow-up actions upon discharge of the person back to the home community. It is expected that this will build the capacity in various local communities to work with people with a dual diagnosis.

Key partners in this Project include the Mental Health Centre Penetang and the Cululpa Community Support Services. Other organizations in various areas of the Central East Region are also partners.

**Website:** <http://www.clhmidland.on.ca/Pineview.htm>

### **Contact:**

Nancy Haans, Coordinator, Community Living Huronia  
Phone: (705) 526-4253

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## **THUNDER BAY – LAKEHEAD PSYCHIATRIC HOSPITAL – ST. JOSEPH'S CARE GROUP**

No specialized program for dual diagnosis currently exists.

### **Long Term Rehabilitation Program**

The Long Term Rehabilitation Program provides both inpatient and outpatient services for clients with Serious Mental Illness (including those with dual diagnosis). A multidisciplinary approach is utilized for both inpatients and outpatients which includes representation from psychiatry, medicine, nursing, psychology, recreation, occupational therapy, vocational rehabilitation, social work, spiritual care and dietary.

### **Inpatient Program**

The inpatient program consists of a 26 bed integrated male and female unit which focuses on serving people with serious mental illness who have complex and unstable mental disorders including psychotic disorders; developmentally challenges; acquired brain injured or concurrent disorders. Clients may be admitted through the Rehab Outpatient or directly from the community. The service is client centered, operates according to best practices and is based on psychosocial rehabilitation principles.

### **Outpatient Program**

Rehabilitation Outpatient Program provides individualized treatment, assessment, consultation and support for clients with Serious Mental Illness. The service is available Monday – Friday 0730 – 1530 hours and Inpatient nursing staff provide after hours care. Clients are referred from either the inpatient or community programs.

#### **Contact:**

Pat Paradis, Rehabilitation Program Manager, Lakehead Psychiatric Hospital,  
St. Joseph's Care Group, 580 Algoma Street N, P.O. Box 2930, Thunder Bay, ON P7B 5G4  
Phone: (807) 343-4385  
E-mail: [ParadisP@tblph.ca](mailto:ParadisP@tblph.ca)

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## **TORONTO – CENTRE FOR ADDICTION AND MENTAL HEALTH (CAMH)**

### **CAMH Dual Diagnosis Program**

The Dual Diagnosis Program is a specialized service for individuals with a developmental disability and mental health needs, their families and care providers. The Program consists of two community based multidisciplinary teams (in Peel and Toronto regions), as well as an inpatient and a day treatment program on the grounds of the Queen St. site of CAMH. All services are coordinated within the broader continuum of supports and services, using approaches that integrate mental health and developmental perspectives.

### **Community Teams**

#### **1) Dual Diagnosis Resource Service (Toronto)**

Provides time limited consultation, assessment and treatment, program recommendations, education, training advocacy and coordination between services offered by different agencies.

DDRS also works in partnership with the Griffin Community Support Network for crisis services. This Network offers short term residential support with an intellectual disability and persons with a dual diagnosis 16 years and over. Fifty partnering agencies are involved in the Network.

#### **Contact:**

Sheila Gittens, Intake Worker, Centre for Addiction and Mental Health (CAMH)  
700 Lawrence Ave. West, Suite 432, Toronto, ON M6A 3B4

Phone: (416) 535-8501, ext. 7809  
E-mail: [Sheila\\_Gittens@camh.net](mailto:Sheila_Gittens@camh.net)

## **2) Dual Diagnosis Service - Peel Region**

Provides consultation, assessment, diagnosis, time limited treatment, program recommendations, system facilitation, crisis planning, education , training, advocacy and coordination and facilitation between services.

### **Contact:**

Karen McMillan, Intake Worker (Peel)  
Phone: (416) 535-8501, ext. 2870  
E-mail: [Karen\\_McMillan@camh.net](mailto:Karen_McMillan@camh.net)

## **Day Treatment Service**

Day treatment is offered for inpatient clients and as an alternative to inpatient admission for clients living in the community. The program offers consultation, assessment, time limited treatment, training and skills development programs. Access to the inpatient unit is through the appropriate community team (above).

## **Inpatient Unit**

This unit has 15 beds for time limited admission, assessment and treatment for clients referred with a dual diagnosis. The inpatient and day treatment program employs approximately 33 staff, including a psychiatrist, a psychologist, a behaviour therapist, a recreational therapist, an occupational therapist, a social worker, a ward clerk, RNs and RPNs Access to the inpatient unit is through the appropriate community team (above).

**Website:** [http://www.camh.net/dual\\_diagnosis](http://www.camh.net/dual_diagnosis)

## **The Griffin Community Support Network**

CAMH's Dual Diagnosis Program is part of, and works closely with, the Griffin Community Support Network. The Network is a partnership of 50 agencies in Toronto that offer time limited specialized assessments and consultations, treatment, short-term case management, short-term residential support, short-term day program support and access to hospital supports for adults with a dual diagnosis or a developmental disability. Depending on the circumstances and the availability of resources, the Network has the capacity to offer staffing support for integrating individuals into community-based settings. The service is for individuals who are not in acute psychiatric crisis and are able to be placed safely in a community-based settings.

The Griffin Community Support Network is a key element of a coordinated, seamless crisis and support service in Toronto.

### **Contact:**

Call a Network Intake Worker at 416-222-3563.

## **WHITBY - WHITBY MENTAL HEALTH CENTRE**

### **Special Populations Program**

The Special Populations Program consists of three distinct clinical services that provide specialized treatment to discrete sub-populations of the severely mentally ill: Dual Diagnosis Service, Neuropsychiatry Rehabilitation Services and Beacon House.

### **Dual Diagnosis Service (DDS)**

This 20 bed unit provides service to adults who are developmentally handicapped with a serious mental illness and who present with significant behavioural problems.

The philosophy of the Dual Diagnosis Service strongly supports a commitment to a collaborative approach to treatment involving clients, families, Schedule 1 hospitals and community based service providers at all stages of the consultation, assessment, treatment and follow up process.

Dual Diagnosis Service is a unique clinical service combining expertise in the assessment and treatment of developmental handicaps with that of psychiatry to offer the client specialized psychiatric treatment and behavioural programming.

DDS offers outpatient assessment and consultation, inpatient assessment and treatment, a day program and follow up services. DDS provides a comprehensive and specialized outreach service to the Whitby Mental Health Centre catchment area. The outreach team includes two community nurse clinicians with access to program psychiatrist/s and other members of the multidisciplinary team, as required. The outreach team provides assessment, consultation, education/training, community liaison and support to clients, family members, community hospitals, associations for community living, community agencies and other community partners.

### **Website:**

[http://www.wmhc2.com/spp.htm#Neuropsychiatry%20Rehabilitation%20Service%20\(NRS\)](http://www.wmhc2.com/spp.htm#Neuropsychiatry%20Rehabilitation%20Service%20(NRS))

### **Contact:**

Dan Roy, Program Manager, Dual Diagnosis Service  
Whitby Mental Health Centre, 700 Gordon Street, Whitby, Ontario, L1N 5S9  
Phone: (905) 668-5881, ext. 6685  
E-mail: [royd@wmhc.ca](mailto:royd@wmhc.ca)

## APPENDIX B: ADDITIONAL RESOURCES AND REGION-SPECIFIC DOCUMENTS

### ADDITIONAL RESOURCES

#### Articles:

Morris, Susan (2005). *Specialized Inpatient Mental Health Units in Ontario: Their History and Program Characteristics*, Mental Health Aspects of Developmental Disabilities, 8 (3).

Lunsky, Y., Bradley, E., Durbin, J., Koegl, C., Canrinus, M., & Goering, P. (2006). *The Clinical Profile and Service Needs of Hospitalized Adults With Mental Retardation and a Psychiatric Diagnosis*. Psychiatric Services, 57 (1).

Lunsky, Y. & Bradley, E. (in press). *Dual diagnosis or dual confusion? Limitations when utilizing non-specialist data*. Journal of Developmental Disabilities.

Lunsky, Y., Garcin, N., Morin, D., Cobigo, V., & Bradley, E. (in press). *Mental health services for individuals with intellectual disabilities in Canada: Preliminary findings*. Journal of Applied Research in Intellectual Disabilities, Special Issue on Dual Diagnosis.

Saeed H, Ouellette-Kuntz H, Stuart H, Burge P (2003). *Length of stay for psychiatric inpatient services: A comparison of admissions of people with and without developmental disabilities*. The Journal of Behavioral Health Services and Research, 30: 406-417.

#### Reports available online:

*Dual diagnosis in Provincial Psychiatric Hospitals: A Population-Based Study*. Lunsky Y., Bradley E., Durbin J., Koegl C., Canrinus M., Goering P., Toronto, Ontario: Centre for Addiction and Mental Health, 2003.  
[http://www.camh.net/pdf/dualdiagnosis\\_provpsychhosp\\_1styr2003.pdf](http://www.camh.net/pdf/dualdiagnosis_provpsychhosp_1styr2003.pdf)

*Response to the Ontario Government Transformation Agenda For Developmental Services: Meeting the Health and Mental Health Needs of Individuals with Developmental Disabilities*, Prepared by: Task Group of the NADD Ontario Chapter. December 2004.  
<http://www.naddontario.org/pdf/FINAL%20Response%20to%20the%20Transformation%20Agenda%20Dec%201.pdf>

*Dual Diagnosis: An introduction to the mental health needs of persons with developmental disabilities*. D. Griffiths, C. Stravakaki, & J. Summers (Eds.) Ontario: Habilitative Mental Health Resource Network. It can be accessed on the NADD Ontario web site:  
<http://www.naddontario.org>

*Policy Guideline for the Provision of Services for Persons with a Dual Diagnosis (developmental disability /mental health needs)* – August 1997, Ontario Ministries of Health and Community and Social Services, Mental Health Programs and Services Unit and Developmental Services Branch

<http://www.psychiatry.med.uwo.ca/ddp/resources&sites/dualdiagnosis/policyguideline.htm>

*Guidelines for Managing the Patient with Developmental Disability in the Emergency Room*, Elspeth Bradley, Lillian Burke, Caroll Drummond, Marika Korossy, Yona Lunskey, Susan Morris, 2002.

<http://www.psychiatry.med.uwo.ca/ddp/bulletins/02marbul.htm>

*Position Paper Respecting Dual Diagnosis*, Canadian Mental Health Association, Ontario Division, Dual Diagnosis Task Force Of the Public Policy Committee, June, 1998.

[http://www.ontario.cmha.ca/admin\\_ver2/maps/98%5F17%2Epdf](http://www.ontario.cmha.ca/admin_ver2/maps/98%5F17%2Epdf)

*Dual Diagnosis: People with Developmental Disability and Mental Illness — Falling Through the Cracks*, CMHA, 1998.

[http://www.ontario.cmha.ca/admin\\_ver2/maps/dual%5Fdiagnosis%5F1998%2Epdf](http://www.ontario.cmha.ca/admin_ver2/maps/dual%5Fdiagnosis%5F1998%2Epdf)

*Building Responsive Service Systems*, Laurie Dart, William Gapen, and Susan Morris.

[http://www.griffin-centre.org/images/up-2Building\\_Responsive\\_Service\\_Systems.pdf](http://www.griffin-centre.org/images/up-2Building_Responsive_Service_Systems.pdf)

*DUAL DIAGNOSIS*, Susan Morris

[http://www.camh.net/pdf/dual\\_diagnosis\\_morris\\_ppao2003.pdf](http://www.camh.net/pdf/dual_diagnosis_morris_ppao2003.pdf)

*Making It Happen Documents*

The Ministry of Health and Long-Term Care's implementation plan for mental health reform, "Making It Happen," provides the framework for a comprehensive, responsive mental health service delivery system throughout Ontario.

[http://www.health.gov.on.ca/english/public/program/mentalhealth/mental\\_reform/makingithappen\\_mn.html](http://www.health.gov.on.ca/english/public/program/mentalhealth/mental_reform/makingithappen_mn.html)

*The Time Has Come: Make it Happen - A Mental Health Action Plan for Toronto and Peel*, Final Report to the Minister of Health and Long-Term Care, Toronto-Peel Mental Health Implementation Task Force, December 24, 2002.

[http://www.health.gov.on.ca/english/providers/pub/mhitf/toronto\\_peel/toronto\\_peel.pdf](http://www.health.gov.on.ca/english/providers/pub/mhitf/toronto_peel/toronto_peel.pdf)

**Ontario Ministry of Community & Family and Children's Services**

Call 416-325-0500.

<http://www.mcscs.gov.on.ca/CFCS/en/default.htm>

**Developmental Services Act – Including “Rules Governing Physical Restraint”**  
<http://www.family-alliance.com/ftpdocs/DevServicesAct.pdf>

**Ontario Ministry of Health and Long-Term Care**  
Call 416-314-5518.  
<http://www.health.gov.on.ca/>

**NADD Ontario - The Ontario Chapter of the National Association for the Dually Diagnosed** <http://www.naddontario.org>

**The National Association for the Dually Diagnosed (U.S. based)**  
<http://www.thenadd.org>

**Developmental Disabilities Division, The University of Western Ontario, Resources website**  
<http://www.psychiatry.med.uwo.ca/ddp/resources&sites/main.resources&sites.htm>

**Community Living Ontario**  
<http://www.communitylivingontario.ca>

**Peel Region Dual Diagnosis Plan and System Design**  
[http://www.cdrcp.com/dd\\_system.html](http://www.cdrcp.com/dd_system.html)

## **EDUCATION AND TRAINING RESOURCES**

*Education and Training Resources in Dual Diagnosis, A Report for the Education Task Group of the Dual Diagnosis Implementation Committee of Toronto, Prepared by: Lori Ann Blessing, September 2001.*  
<http://www.psychiatry.med.uwo.ca/ddp/bulletins/educ&train.htm>

*Education Training Package in Developmental Disabilities for Medical Undergraduates, Provincial Health Sciences Centres, Ontario, Canada*  
<http://www.psychiatry.med.uwo.ca/ddp/mededucation/titlepage.htm>

*York University Certificate in Dual Diagnosis*  
Co-Sponsored with The School of Social Work, Atkinson Faculty of Liberal & Professional Studies  
<http://www.atkinson.yorku.ca/~dce/Programs/Certificates/DualDiag/DualDesc.html>

*Community Living Ontario – Calendar of events*  
<http://www.communitylivingontario.ca/calendar/cal05.html>  
<http://www.communitylivingontario.ca/calendar/cal06.html>

*Generalist Practice Level in Dual Diagnosis: Self-Assessment Form*

Published in 2004 by the Training and Education Work Group of the Dual Diagnosis Implementation Committee of Toronto. The tool can be used by providers across the sectors to evaluate their skills.

[http://www.camh.net/pdf/dual\\_diagnosis\\_generalist\\_selfassess.pdf](http://www.camh.net/pdf/dual_diagnosis_generalist_selfassess.pdf)

*Levels of Practice for Supporting Individuals with Dual Diagnosis*

This document has been developed as a framework to allow continued development of the capacity and expertise of professional and paraprofessional personnel engaged in treatment and support roles with persons who have an intellectual disability and mental health needs. The intention is to delineate the knowledge, skills and attitudes required by staff working at varying levels of practice.

[http://www.camh.net/pdf/dual\\_diagnosis\\_levelsprac\\_generalist.pdf](http://www.camh.net/pdf/dual_diagnosis_levelsprac_generalist.pdf)

*NADD Educational Resources*

<http://www.naddontario.org/training.html>

**The Developmental Consulting Program**

The Developmental Consulting Program (DCP) is a multidisciplinary network of researchers, educators and practitioners at Queen's University in Kingston who provide training, research and consulting in developmental disabilities.

**Contact:**

Barbara Stanton, Coordinator, Developmental Consulting Program (DCP)

**Email:** [dcp@post.queensu.ca](mailto:dcp@post.queensu.ca)

**Phone:** (613) 544-4885 · **Fax:** (613) 544-4886

**The International Certificate Programme in Dual Diagnosis**

Intensive Training Courses in Habilitative Mental Health for Persons with Developmental Disabilities: A certificate programme offered by Brock University, St. Catharines, Ontario, Canada, in association with Niagara University, Lewiston, New York, USA.

Courses are offered in June of each year. Please refer to the "Summer Institute 2006" links for course offerings and dates.

**Website:** <http://www.brocku.ca/dualdiagnosis/>

To request a print version of the brochure, please email [dualdiagnosis@brocku.ca](mailto:dualdiagnosis@brocku.ca), or mail a request to:

Carol Penner, Brock University

500 Glenridge Avenue, St. Catharines, ON L2S 3A1

**Dual Diagnosis National Wide Community of Practice (COP)**

For the past 24 months, a group of dedicated clinicians representing Dual Diagnosis programs across Ontario have conducted educational events through live interactive videoconferencing.

These teams gather monthly to engage in sharing and learning, based on common interests and challenges, bonded by their experiences in this specialized domain of mental health care.

The Dual Diagnosis Community of Practice strives to provide the communications playing field accessible for all Dual Diagnosis teams in Canada who value team-based growth through the design of this technology-enabled engagement that brings a wealth of collective knowledge together every month.

**Contact:**

Chair-Facilitator: Debbie Champ, RN, CPMHN (C)  
Dual Diagnosis Consultation Outreach Team, Royal Ottawa Hospital  
Ottawa—613.722-6521 ext. 7136

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**REGION-SPECIFIC DOCUMENTS**

**BRANT**

*GRAND RIVER DISTRICT HEALTH COUNCIL BRANT DUAL DIAGNOSIS SERVICE PLAN  
DECEMBER 7, 1999.*

<http://www.champlain-dhc.org/protected/uploaded/publication/brant%20dual%20diagnosis%20service%20plan.pdf?lang=en>

**BROCKVILLE /OTTAWA**

*“Dual Diagnosis Plan for the Champlain District, May 2000”*

Foundations for Reform, Section 9.1, *“Dual Diagnosis Service of Brockville Psychiatric Hospital, Recommendations for Implementation, July 2002”*

[http://www.health.gov.on.ca/english/providers/pub/mhitf/east\\_ne/sec91.pdf](http://www.health.gov.on.ca/english/providers/pub/mhitf/east_ne/sec91.pdf)

**HAMILTON**

*“Hamilton Community Service Plan For Developmental Services”, August 2004.*

<http://contacthamilton.ca/docs/Hamilton%20CSP%20for%20DS%20Aug%202004.pdf>

**KINGSTON**

*“Building Resource Systems for Persons With a Dual Diagnosis,”* A report prepared for Michael Park, Executive Director Southeastern Ontario District Health Council Submitted by The Developmental Consulting Program, Kingston, September 2001. [http://www.champlain-dhc.org/protected/uploaded/publication/36\\_buildingresourcesystems.pdf?lang=en](http://www.champlain-dhc.org/protected/uploaded/publication/36_buildingresourcesystems.pdf?lang=en)

*“Advocating for the Establishment of Three Extended Treatment Units for Persons with a Dual Diagnosis Living in Southeastern Ontario,”* Feb. 2005, written by Dr. Bruce McCreary, Philip Burge and Dr. Jessica Jones.

## **LONDON**

*“London and Middlesex Dual Diagnosis Report,”* June 2004  
<http://www.psychiatry.med.uwo.ca/ddp/lmddreport.htm>

## **NORTH BAY**

*“Regional Longer-Term Specialized Adult Mental Health Beds: Proposal for the dedication of beds for individuals who have a developmental disability and serious mental health concerns”* September 2003.

*“Northeast Mental Health Centre North Bay Psychiatric Hospital Regional Longer-Term Specialized Adult Mental Health Beds – Dual Diagnosis, 2003”*

*“North East Regional Office Review of Clinical Services for Persons with Developmental Disabilities, August 1999.”*

For further info on obtaining these documents, contact Garry Fay at  
[Garry.Fay@NBPH.MOH.GOV.ON.CA](mailto:Garry.Fay@NBPH.MOH.GOV.ON.CA)

## **PENETANGUISHENE**

*“2003/04 Annual Report,”* Central East Region, Adult Developmental Services Group.  
For further info on obtaining this document, contact Nancy Pilon at [npilon@mhcp.on.ca](mailto:npilon@mhcp.on.ca)

## **THUNDER BAY**

*“Dual Diagnosis Plan for Northwestern Ontario,”* Northwestern Ontario District Health Council and Ministry of Community and Social Services, Northern Region, Thunder Bay and Kenora/Rainy River Districts, July 1999.

For further info on obtaining this document, contact Pat Paradis at [ParadisP@tblph.ca](mailto:ParadisP@tblph.ca)

## **TORONTO**

*“Supports and Services Resources Handbook,”* A Resource Handbook For Supports and Services for Persons With a Dual Diagnosis in Toronto, 2002 edition.  
[http://www.camh.net/pdf/concernparents\\_dualdiagbdbk.pdf](http://www.camh.net/pdf/concernparents_dualdiagbdbk.pdf)

## **SIMCOE (BARRIE/NEWMARKET/PENETANGUISHENE)**

*“Improving Services for Simcoe County Residents with a Dual Diagnosis -Executive Summary,”*  
Prepared by the Simcoe County Dual Diagnosis Committee November 18, 1999.

<http://www.champlain-dhc.org/protected/uploaded/publication/improving%20services%20for%20simcoe%20county%20residents%20with%20a%20dual%20diagnosis.pdf?lang=en>

*“Supports and Services for Persons with a Dual Diagnosis: A Resource Manual for Simcoe County Families,”* Prepared under the direction of the Simcoe York Dual Diagnosis Education Committee, September 2004.

<http://www.champlain-dhc.org/protected/uploaded/publication/simcoe%20supports%20and%20services%20for%20persons%20with%20a%20dual%20diagnosis%20.pdf?lang=en>

**Connecting Simcoe website for the Information Providers Coalition of Simcoe County**

<http://www.connectingsimcoe.info/>

## **YORK/WHITBY**

*“Plan for the Provision of Services to Individuals with a Dual Diagnosis in York Region,”* March, 2001.

<http://www.champlain-dhc.org/protected/uploaded/publication/plan%20for%20the%20provision%20of%20services%20to%20individuals%20with%20a%20dual%20diagnosis%20in%20york%20region.pdf?lang=en>

*“Supports and Services For persons with a Dual Diagnosis, A Resource Manual for York Region Families,”* August 2004.

<http://www.yssn.ca/handbook.pdf>

## APPENDIX C: ADVISORY COMMITTEE MEMBERS

Cheryl Bedard  
*Surrey Place Centre - Toronto*

Sandra Bockus  
*Centre for Addiction and Mental Health - Toronto*

Laurie Buttineau  
*Mental Health Centre Penetanguishene*

Neill Carson  
*Centre for Addiction and Mental Health - Toronto*

Alex Conant  
*Providence Continuing Care Centre - Kingston*

Sue Delamere  
*Lakehead Psychiatric Hospital - Thunder Bay*

Janet Durbin  
*Health Systems Research and Consulting Unit, CAMH*

Paul Eshleman  
*North Bay Psychiatric Hospital*

Garry Fay  
*North Bay Psychiatric Hospital*

Jay Fraser  
*Brockville Psychiatric Hospital - Royal Ottawa Hospital*

Dr. Jeremy Goldberg  
*Hamilton Health Sciences Centre*

Susan Morris  
*Centre for Addiction and Mental Health - Toronto*

Monica Neitzert  
*Developmental Services Branch - Ministry of Community and Social Services*

Dr. Jay Rao  
*Developmental Behavioural Management Unit*

Pam Roe  
*Regional Mental Health Care London*

Dan Roy  
*Whitby Mental Health Centre*

Paul Secord  
*Mental Health and Addictions Branch, Ministry of Health and Long Term Care*

Larry Silk  
*Mental Health Centre Penetanguishene*

Marc Simpson  
*Mental Health Centre Penetanguishene*

Jane Summers  
*Hamilton Health Sciences Centre*

Paul Wallace  
*Royal Ottawa Hospital*