

NADD ONTARIO CHAPTER NEWS
Habilitative Mental Health Resource Network

A Twice Annual Bulletin of the Habilitative Mental Health Resource Network

Spring 2004

This newsletter is available to members of NADD and subscribers in Ontario and across Canada. If you wish to receive two editions a year, please complete the form on page .

CHECK OUT OUR UPDATED WEBSITE <http://www.dualdiagnosisontario.org/>

I am pleased to announce that our book on “Dual Diagnosis” is in great demand and we had to order a second printing of the book! As well, there remains a limited number of the French version available. We understand that the Ministries of Community and Social Services and Children’s Services distributed training dollars across the Province in February/March 2004, promoting the use of the book as the basis for training. While this was an exciting opportunity for local communities to come together around dual diagnosis training, the NADD Board is aware that the process used for “training the trainers” was inconsistent across the Province.

Our organization supports, promotes, and advocates for the needs and services of the dually diagnosed. However, this is a very specialized area and those of us who are involved with dual diagnosis in any capacity either as family, professional or direct care providers, we recognize the need not only to educate ourselves but those around us in order to enhance full integration of the dually diagnosed into the community. Additionally, effective training in this field must go beyond didactic approaches and incorporate opportunities for people to share their experiences and knowledge. Therefore, for any future provincial training initiatives we recommend that there should be adequate time allotted for preparation and coordination with the goal of ensuring sustained results.

I have in the past and will now again encourage our members to give voice to their thoughts and to become actively involved in the organization. There is tremendous potential in our organization to deal with a wide scope of issues concerning dual diagnosis. The task of the Board in attempting to span a variety of issues can seem overwhelming. Our members input in determining our priorities and direction is invaluable. Let us know what you are thinking! You can visit our website and e-mail any member of the Board with your ideas or write to our Editor, Susan Morris.

In the end I am reminded of a quote:

"Tolerance is only a beginning towards becoming a whole being. It is not enough to only be tolerated. We must move toward complete respect and total acceptance. "
Anonymous

naseema
MESSAGE FROM THE CHAIR
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INTERMINISTERIAL NEWS

Dual Diagnosis in Provincial Psychiatric Hospitals: A Population – Based Study by Y.Lunsky, E.Bradley, J.Durbin, C Koegl, M Canrinus & P. Goering.

Funded by the Ontario Mental Health Foundation as a two phase project, below is a summary of key findings from Phase 1 of the study, *Description of dual diagnosis subgroup and its needs in the PPH system*. Phase 2 of the study, *Key Informant study of dual diagnosis in the PPH system* will begin in June 2004. Dual Diagnosis, for the purpose of this study is defined as a person with a developmental disability and concurrent psychiatric concerns. Using data generated from nine Comprehensive Assessment Projects (CAPs) in Provincial Psychiatric and Speciality Hospitals in Ontario from 1998 to 2002 (12,960 patients), individuals with a dual diagnosis were examined in terms of demographic and diagnostic characteristics and clinical/support needs. Below are *excerpts* from the Key Findings and Recommendations, published with permission of the Principle Investigator. For more information contact yona_lunsky@camh.net. Full copies of the report are accessible at:

Prevalence: As many as **13% of PPH users (inpatient and outpatient) have a dual diagnosis with some sites** (e.g. Penetanguishene Mental health Centre) identifying as many as 36%. Developmental disability is more common than any other disability in the psychiatric hospital population.

Comparison to those without dual diagnosis

Individuals with a dual diagnosis are younger, more likely to be single and unemployed and living in dependant settings with long inpatient admissions than other individuals in the PPH system. They are less likely to receive certain diagnoses (substance abuse, mood disorder) but equally likely to be diagnosed as psychotic and equally likely to have legal issues as other patients. Their most significant problems are in the areas of self-care, aggression and security/management issues but they have higher symptom ratings on most symptoms when compared to patients without a dual diagnosis combined with fewer economic, educational, internal and external (social support) resources. They have higher recommended levels of care than other patients and higher needs with regard to clinical services and supports.

Specialized Dual Diagnosis Programs

Seven specialized dual diagnosis programs serve 20% of patients with a dual diagnosis in the PPH system. This represents programs that provide inpatient and/or outpatient services. Patients served by these programs are typically younger, more frequently male, have significantly more issues related to aggression than other patients with a dual diagnosis. They have higher reported symptom severity and greater needs than other patients with a dual diagnosis. Despite being in specialized programs, their unmet need is even greater than for patients with a dual diagnosis in the generic PPH programs.

Patient Characteristics

PPHs are serving equal numbers of men and women with a dual diagnosis. They come from a range of backgrounds, ages and residential settings. Most have limited education and are unemployed, two of the most important determinants of mental and physical health. The most common diagnosis is psychotic disorder, even in outpatient settings where mood and anxiety disorders are more prevalent in the general population. Mood and anxiety disorders are not common diagnoses although research would suggest that they are *undiagnosed*. The majority of individuals with a dual diagnosis served have mild developmental disabilities as opposed to severe impairments.

Gender issues

Equal numbers of men and women with a dual diagnosis receive services at the PPHs, however significantly more men are served in both inpatient settings and specialized dual diagnosis programs. Women, like women in the general PPH population are more likely to have experienced past trauma or loss than men and they also have higher rates of suicide attempts prior to receiving PPH services.

Aging Issues

Older individuals with a dual diagnosis are medically compromised than younger individuals and have unique clinical concerns and diagnostic issues. Their recommended

level of care is higher overall than the recommended level of care for other older adults but not when compared to younger individuals with a dual diagnosis.

Legal Issues

Individual with a dual diagnosis (80% male) are as likely as anyone else to have legal problems. There is the same percentage of individuals with a dual diagnosis in the legal system as individuals without a dual diagnosis. These individuals tend to remain in the 'unfit to stand trial' phase of the forensic process and may be hospitalized for long restrictive sentences as a result.

Inpatients

Inpatients with a dual diagnosis make up as many as 19% of inpatients served in the PPH system. Thirty-seven percent (37%) of inpatients with a dual diagnosis have been in hospital for longer than 5 years. These individuals have major medical comorbidities and are significantly older than the general dual diagnosis population. They tend to be inpatients not because of severity of their difficulties but because there are no appropriate places to discharge them.

Outpatients

A small proportion of these individuals are living with parents, but a majority are either independent or living in group home or boarding home situations. They receive a mood disorder diagnosis more often than patients from other settings but are still probably over diagnosed with psychotic disorders.

Recommendations (for complete list of recommendations see full report):

1. Hospital administrators, policy makers and the MOHLTC and MCSS need to be made aware of the high percentage of patients in the PPH system with a dual diagnosis as they are grossly underserved.
2. **All staff in the PPH system require training to recognize and meet the unique needs of patients with a dual diagnosis.**
3. Individuals specially trained in the area of dual diagnosis should be available to each program at each hospital to assist in providing appropriate assessment and treatment services.
4. Greater efforts should be made to recruit and retain staff who are trained to work with patients with a dual diagnosis in specialized dual diagnosis programs, given how challenging these patients can be.
5. Protocols and appropriate placement options need to be developed that take into account the severity of aggression displayed by patients serviced in specialized dual diagnosis programs.
6. Further investigation into diagnostic practices with this population is necessary to determine whether psychotic disorders are being over diagnosed while mood and anxiety disorders are being under recognized. If this is the case, training is required to help clinicians make more appropriate diagnoses and treatment recommendations for these individuals.

7. Women's mental health programs need training on issues of concern for women with a dual diagnosis as well as ways to modify their approach to meet needs of such women.
8. Many crises could be prevented for outpatients with a dual diagnosis if a more proactive approach could be taken, which would include availability of an interdisciplinary team with an understanding of the developmental disability as well as the mental health concern.

LOCAL COMMITTEE UPDATE / CONSUMER AND FAMILY SUPPORT

On March 26th the Toronto MOHLTC, MCCS regional offices and the Dual Diagnosis Implementation Committee hosted a cross sector forum for front line staff and managers. The goals of the day were to exchange expertise and perspectives between developmental and mental health providers, to address opportunities and challenges in building shared care approaches across service sectors and to identify linkages, partnerships, opportunities and challenges. The feedback from the 170 participants was exceptionally positive. One highlight of the day was the privilege of hearing Jim Johnston and John Mohler speak about the family perspective of services. Below are excerpts from their comments:

Mr. Jim Johnston:

You do extremely important work that effects the lives of individuals and families. This important work is not as well recognized as it should be by society. Our understanding of the needs of those with a dual diagnosis has grown. There are new insights from the clinical research, and from family input, BUT we have a long way to go. Everyone in this field must have access to the latest information and training so they can provide the most effective service and we must have the flexibility to provide this service. We can get the knowledge through forums like this, through reading and with the close collaboration of other disciplines on building solutions for individuals...

When Concerned Parents of Toronto published our Supports and Services Resource Handbook, we gave copies to each agency and urged them to share them with parents. A manager in one large agency told us that they really didn't need the information since "we know all about dual diagnosis, we serve lots of them". This bothers me - the working assumption should be that you don't know enough about this issue, and that everyone should take every opportunity to learn more.

I'm sure that you will understand how rejection, teasing, loneliness, isolation and even sexual abuse can lead to emotional outbursts, anger, aggression, depression. Having a child with a dual diagnosis creates great pressures in the family. As the mental health issues manifest themselves, the family is unsure how to help the family member. Are the behaviours a result of the intellectual disability or are there other factors involved? Stress and frustration effect all members of the family often leading to physical or psychological symptoms in family members. Help seems fragmented, remote and very difficult to obtain ...

It reminds me of the story of a man who went for psychiatric help. When he entered the office, he was faced with 2 doors men, women. He opened and went through the door labelled men and was confronted with two more doors / introvert, extrovert. He opened and went through the introvert door, and saw two more doors - dually diagnosed or not dually diagnosed. He opened and went through the door labeled dually diagnosed and found himself back on the street.

Last week an adult with a dual diagnosis was referred to the psychiatric department at a general hospital. The hospital rejected the person for treatment because the case was 'too complex'. If the psychiatric department of a general hospital believes that the case is too complex to treat, where does that leave the parents who have been trying to give care for years? ...

At a recent seminar, I listened to a debate between mental health and developmental sector professionals. Mental health argued that the developmental sector was not able to provide 'step down' services for those who have a dual diagnosis and are discharged from psychiatric hospitals. The argument from the developmental sector was that there were programs in the developmental sector that could do this. Mental health, however, countered that the developmental sector put these people in 'programs' and even the stress of having a 'day program' would be too much for some patients - they may need to have no structure for a period.

As I listened, I wondered why we don't have a system where Health and Developmental sectors co-operate to determine the best for each consumer, which would then drive required changes to the system rather than this critique and defensive reaction cycle. It can be complex to understand how intellectual disability and mental health problems interact. Mental health problems can be mistakenly seen as part of the disability. If a person is impulsive, withdrawn, or irritable, this may be attributed to the intellectual disability and many are improperly diagnosed and overly medicated.

Behavioural issues are often a way for the individual to tell us that something is wrong. For example, in a day program, a young woman started to slap her abdomen regularly. This was seen as a behavioural issue - likely self abusive behaviour that should be controlled. Finally a staff insisted on a medical review, and it turned out that the young woman had an ulcer. Sometimes we need to really think of what could be causing a behaviour.

In fact agencies are often unwilling to accept those that have behavioural issues because they are disruptive to the program, and take more staffing. Government funding must be flexible enough to recognize this and step up to these funding issues quickly. Collaboration, cooperation and coordination are essential so that the **two sectors together can produce a more responsive service system**. I am getting tired of sitting in meetings where only systems are discussed. We need as many meetings discussing how individual's problems are being addressed. Coming up with solutions for individuals will drive better system designs.

Case managers who understand both systems and can work with families in supporting them and finding appropriate resources are urgently needed. Unfortunately some case managers only understand one of the sectors or sometimes only their own agency and are not effective in helping families find integrated supports from both sectors. Families want to ensure that the quality of programs are high. Surprisingly there are few external measures of quality for developmental programs such as accreditation of the organization. What do families want? In our experience they continue to ask for:

1. Coordinated assessments – where developmental, mental health and physical factors are all assessed and integrated so that an effective plan can be created.
2. Accreditation or other measures of quality that allow families to assess which agencies meet or exceed standards of excellence in their programs.
3. Recognition by government that workers in this field must be highly skilled and paid, current salaries are not enough to attract and keep good staff.
4. Access to case management support that can help the family navigate both sectors and receive general support to keep the family unit strong.
5. Assurances that services will be there when families can no longer support their children
6. Better education for psychiatrists and medical doctors in the field of dual diagnosis
7. Flexibility including individualized funding and the ability to move with the funding if an agency does not provide acceptable services
8. Finally and most importantly, for respect for our children, seeing them as valued members of society.

Families we know are willing to do as much as it takes for as long as it takes to get proper supports for their children. The fact is that current supports are not adequate for our adult children. Having a son or daughter with an intellectual disability is tiring, physically and emotionally. **The addition of mental health needs can be crushing.** These families need help in finding the right supports for their son or daughter and in coping with the situation. For you, the family is a key resource to understand the person who you are supporting. Families and workers must listen to each other and understand each one's point of view.

Mr. John Mohler:

I am the father of 2 sons with a dual-diagnosis. That means that they often need your help, and I need your help. I have also been part of this DDIC working group for over 2 years but there are other family members here who have been active for much longer – a whole lot longer if you include other groups, other forums, or other projects.

So, I thought I could share some insights with you – but you are the people who meet us on the phone, at your desk, in our homes, or at the counter. I expect that you already know a lot about our frustrations, our anger, and our experiences - I guess you hear it

everyday. It might make more sense then, if I tell you some of my goals – what I hoped we could accomplish in the DDIC, and what we might achieve today.

I hope what you hear today is a clear message from the ministers and ministries involved that **service for the dually diagnosed must be barrier-free**. It is also necessary that each ministry (and the service providers) cooperates with the other on the same level as within each ministry – or even better. We must make the structure work for us - not against us.

Possibly today, we'll receive an equally clear message back from you – on what works and what is needed to make these policies, these measures work. Is this day about empowerment? Possibly not, but hopefully it is about contribution and collaboration.

When my family needs services, I'd like to enter through one door. I'd like not to worry so much if I am in the right place. I'd like to tell you my story, give you my information, and let the system take over from there. I'd like you to be our navigator. You also need to be our translators because families don't talk your language – we can't – we come in talking about our family, our hopes our dreams and you need to translate those hopes into your language - resources, budgets, availability...and waiting lists. There is probably never enough resources...there wasn't yesterday...and there won't be tomorrow either, so your energy and creativity becomes so important to families.

I'd like this day, in some way, to lead to more effective systems; better integrated, so you can do your job easier - and I get better service. I hope that we uncover the means to broaden your knowledge about cross-sector policies, procedures, who's who - and what's available. Lastly I hope you will find some opportunities for education and training.

I hope that you'll be able to tell us “yes” more quickly. And if you do have to tell us “no, there is no room at the inn”, I'd like to hear that right away too. I don't want to wander down the road looking for another solution if you already know it isn't there. So that means we'd like you to be our scout, too.

It is also important to remember that not all families are able to respond well to programs, products, or packages. We cannot be interested in what is easy for you to organize. Not unless it leads to an effective result for us. The system needs to learn to fit around the individual, not the individual adapting to the systems needs. There will be however some families for whom it may be helpful or even necessary to turn matters over to you. But, for many others it is more important to plot and manage their own course.

Most of all we need CHAMPIONS! There are a whole bunch in attendance here today. Champions are those people who always seem to be able to make things happen. It doesn't even seem to matter what their title is or even what they do or where they work – they just seem to be able to help you along the path. I'm never sure if they succeed because of the system – or in spite of the system. Maybe...we can start today to create a better environment to encourage more champions.

Last, but not least. Families hope that this isn't deja vue all over again. We readily admit to a selfish interest that today we've begun something creative and even courageous here! Nothing I've said seems very learned, concrete...or even new!. It sounds a lot like just plain common sense...But if we all – that means you and me – have to live - or spend our careers combating insufficient funding, a lack of resources, or a lack of space, then I guess it is even more urgent and important to become more effective at what we do. I guess we could call that my main goal for the day.

And thanks again. I'm not sure if we families say that often enough. Usually we are at your door demanding what you can do for us. But, maybe today is also a day when you should ask what we can do for you. We will be joining you in all of the workshops. Use us as a resource - we will share our worries and ideas with you. Maybe that will be a good start.

Thanks for this opportunity. I am glad to be here.

UPDATE FROM THE BOARD OF DIRECTORS

Meet a New Board Member

Wendy Pascoe has been a social worker at Developmental Clinical Services in Sudbury for the past 5 years where she works with both children and adults with developmental disabilities and/or pervasive developmental disorders, and their families. She is particularly interested in groups, and currently co-facilitates both relationship skills and anger management groups for adults with global developmental disability. Prior to working with DCS, she lived out west for several years and ran a community college human service worker program in British Columbia. While missing the mountains, she is enjoying living in the land of rocks, trees, and lakes and being closer to her family in southern Ontario.

Book Update

Web Stats

Since September 2003, we have had 16,713 hits to our web page from Belgium, New Zealand, UK, US, Singapore, Philipines, Australia, Greece, Austria, Brazil, Ireland, Germany, Israel, Japan, Czech Republic, Malaysia, Netherlands. As a sample: during February Chapters 5 (Comprehensive Screening and Assessment) and 13 (Sexuality and Mental Health Issues) of the book were accessed more than the rest of the site. During March, Chapters 1 (Forward), 4 (DSM-IV and How it Applies) and 13 have been popular.

Education Committee

The Training Survey distributed to the local dual diagnosis committees resulted in 12 responses out of a potential in the Fall of 2003. Eight committees reported using the book "Dual Diagnosis: An Introduction to the Mental Health Needs of Persons with Developmental Disabilities" in local agency, region wide and a few college/university

training initiatives. Respondents also told us that the format for training that they preferred included conferences, intensive full day sessions, brief local workshops and train the trainer opportunities (the latter receiving the highest number of responses). It was felt that NADD Ontario could support local training in the following ways: speaker information, assistance with the use of the book, partnership with existing training groups (highest number of responses) and organization/provision of training. Additional comments/suggestions from respondents included: training for therapists re how to adapt generic therapies, website based education, teleconference training, website information re available training opportunities.

LETTERS TO THE EDITOR

Please tell us what do you think? About program, treatment or planning issues. Tell us what is happening across Canada. E-mail your comments c/o Susan Morris at susan_morris@camh.net

CALL FOR PARTNERSHIP IDEAS

Send us a one page description of effective approaches and/or programs and it will be published in this newsletter. Include the major characteristics of the individual(s) being served, the major issues, the various roles of those involved in the partnership and why it is working. Fax your description to Susan Morris at 416-463-4025

HERE AND THERE

Ontario's Highest Honor for Dr. Ben Goldberg

The Order of Ontario was established in 1986 to recognize and honour those who have enriched the lives of others by attaining the highest standards of excellence and achievement in their fields. Dr. Ben Goldberg received with this prestigious honor along with 24 other Ontario recipients in March 2004. Throughout his career, Dr. Goldberg has specialized in treating children with autism, developmental disabilities and psychiatric problems. From 1960 to 1965, Dr. Goldberg served as the First Chief of Psychiatry at the Child & Parent Resource Institute in London, Ontario. He was the first Director of Treatment, Training and Research from 1971 to 1988, and at the same time served as the first Coordinator of Child Psychiatry at the University of Western Ontario from 1973 to 1983. He also served as the founding Director of the Developmental Disabilities Program at the University of Western Ontario where he trained residents and other physicians in more effective ways to treat individuals with developmental disabilities. In addition, he has been a consultant for the United Nations Rehabilitation Directorate. In 1970, with Dr. Goldberg's leadership, the Child and Parent Resource Institute in London received the American Psychiatric Association Gold Award as the most comprehensive children's psychiatric mental health service in North America. Those living in Southwestern Ontario are particularly familiar with Dr. Goldberg who continues, when the nice weather does not beckon from the links, to provide psychiatric services during his retirement.

Increased Investment in Autism Services was announced by the Minister of Children and Youth, Dr. Marie Bountrogianni in March 2004. Additional resources are directed toward pre-school Intensive Behavioural Intervention services, provide supports to school age children in the classroom through enhancing knowledge and skills of educators and providing support to parents and undertaking a campaign to recruit clinical psychologists and therapists to work in the field. Critics of this announcement feel this does not address the needs of those pre-school children on waiting lists who have been unable to access the IBI program at a key stage in their life.

Canadian Community Health Survey by Statistics Canada reports that one in 10 Canadians has experienced a psychiatric disorder in the past 12 months. (2002) Major Depression was reported by 4.5% of respondents, alcohol dependence was reported in 2.6% of respondents. In comparison, 5% of Canadians suffer from diabetes and 5% from heart disease. (Cross Currents, the Journal of Addiction and Mental Health, Spring 2004, Vol. 7 No. 2) Health Canada also estimates that the medical care cost of psychiatric disorders in 1998 was \$4.7 billion. The same study however only found that 32% of people with mental health problems sought professional help. Typically general practitioners are approached for assistance. For more information:
222.statcan.ca/english/freepub/82-617-XIE/

Video Conferencing for Dual Diagnosis is coming to areas in the southwest and Northwest of Ontario. MCSS announced in early 2004 the funding of two projects to provide specialized health and clinical services to adults with a dual diagnosis. Regional Support Associates in the southwest area is working in partnership with Community Living Windsor, Community Living Owen Sound, Family Services London, and Haldimand and Norfolk REACH. Surrey Place Centre as lead agency with a number of partners (Griffin Centre, George Brown College, CAMH, Geneva Centre, Bob Rumbal, Community Living Toronto is working with Sioux Lookout and Hudson Association for Community Living and Dryden and District Association for Community Living.

INFORMATION RESOURCES

Interesting WEB Sites:

<http://www.ddhealthinfo.org/ggrc/doc2.asp?ParentID=5298> Aggression and self-Injurious behaviour – description, causes, medical management. Found in Developmental Disabilities Digest.

<http://www.nadd.org> Click on Webcast-Online Seminars - digitized versions of select presentations delivered in a "Pay-Per-View" manner. These seminars were video taped at NADD National and International conferences and feature renowned experts in the field of Mental Health Care for persons with Developmental Disabilities. Nearly all of these seminars are 90 minutes in length. You can view your selected seminar as often as you want within 24 hours of first viewing The topics covered include: Administration & Systems, Aging, Counseling & Therapy, Diagnosis & Assessment, Drug Therapy, Family Issues, Offenders, Program Models, Research, Residential Services, Social & Sexual

Issues, Staff Training and Syndromes. Members pay \$9.95 US, Non-members pay \$12.95 US

Support Resources

LookingUp – Monthly international autism newsletter for parents and professionals. Provides a mix of the very latest findings in autism research from around the world and articles which explore the impact of autism in all areas. Articles include autism in the family, school and further education, employment, film and the other arts, politics, sport and society. For more information: <http://www.lookingupautism.org/>

EDUCATIONAL EVENTS

Certificate in Dual Diagnosis Offered by York University, Division of Continuing Education. Program consists of 6 courses, which combine to a total of 91 hours of instruction. Directed to managers, supervisors and front-line practitioners who want to learn theoretical knowledge and increase their understanding of the needs of clients with a dual diagnosis. Practitioners from the developmental services, mental health, social services, corrections, medical/ health services will find the program relevant to their work. For information see:

www.atkinson.yorku.ca/~dce/Programs/Certificates/DualDiag/DualDesc.html or contact: Domenica Lam, Program Assistant, Division of Continuing Education; Phone: (416) 736-2100, ext 44619. Email: dlam@yorku.ca.

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, New York, USA, and the NADD. For more information call: 905-688-5550 ext 3740, fax 905-682-9020 (Janet Sackfie) or email the Registrar (Margaret Bernat) at mbernat@spartan.ac.brocku.ca

The Habilitative Mental Health Resource Network reserves the right to edit material submitted for publication.

DO YOU WANT TO JOIN NADD?

Call or write NADD at 132 Fair St, Kingston, New York 12401-4802. Telephone 845-331-4336, Fax 845-331-4569. E-mail: nadd@aol.com. Web site: <http://www.thenadd.org>
Inquire about family, student, individual and organizational memberships. Cost is paid in US dollars with 20% returned to support Ontario Chapter activities. With NADD membership you receive this bulletin free of charge.

DO YOU WANT TO SUBSCRIBE TO THIS NEWSLETTER WITHOUT JOINING NADD?

Advertising Feature

The Ontario circulation of the newsletter is about 150 individuals, families, professional and paraprofessional staff and organizations. Quarter (25\$), half (50\$) or full (100\$) page advertisements will pay for inclusion in the Fall and Spring editions. To submit, contact Susan Morris at 416-583-4353 ext. 1136 or susan_morris@camh.net.