NADD ONTARIO CHAPTER

NEWS

Habilitative Mental Health Resource Network

Fall 2005
A Twice Annual Bulletin of the Halibitative Mental Health Resource Network

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contactus@dualdiagnosisontario.org

Message from the Chair
Naseema Siddiqui, Chair

Merry Christmas, Happy Holidays and a Happy New Year.

It is a pleasure and honour to serve as President of the NAAD, Ontario. My experience on the Board over the past number of years has given me great appreciation and respect for the members of the Board for their professionalism and commitment to the field of dual diagnosis. As we know the closure of the remaining three Facilities for developmental disability will bring new challenges. The Minister of Community and Social Services, Hon. Sandra Pupatello has announced several initiatives to enhance community services for individuals with a developmentally disability. It is our undertaking to ensure that individuals with a dual diagnosis are not left behind.

During the Summer the Board developed a strategic plan to address the changing dynamics in the sphere of developmental disability/ dual diagnosis. The Board tackled a variety of issues like services, training, advocacy etc. and it became increasingly evident that this is a time of great fluidity. This is a time in our history where we are being challenged with navigating frequent and overlapping transitions in our field and professional lives.

So, what is our best response to all this uncertainty and change? It is imperative that we step up, anticipate the changes and prepare for the new challenges. Look hard at how we do business now and how we prepare for the future. Are there new services we could be providing, or providing them in different ways? Are there training needs we could assist with?

As I mentioned earlier the Board developed a strategic plan for the Association, but as somebody said "a vision, no matter how noble, will remain just that without a detailed map that shows how that vision can be achieved". A very critical element of our "detailed map" is resources and most importantly human resources. I would ask our members to get more involved. The Membership Committee has sent out a "brief" survey and your support in filling out the survey will be helpful and greatly appreciated.

The Education Committee organized a workshop at the AGM. The workshop on Behavioural Implications of Genetic Syndromes, examined a number of syndromes that have specific behavioural phenotypes. The importance of correctly identifying syndrome driven behaviour was discussed along with recommendations for support and services. The presenter, Dr. Karen Baker, is a psychologist with Regional Support Associates and her scope of practice includes the diagnosis of developmental disabilities and mental health disorders in children and adults.

The efforts of the Communication Committee are well reflected in our website and the Newsletter, both of which continue to be a great resource to our members, and many other professionals.

Last, but certainly not least I would like to take this opportunity to welcome Karen Hirstwood, a new member to the Board, who will be fully profiled in an upcoming Newsletter.

Naseema Siddiqui, President

LETTERS TO THE EDITOR

Please tell us what do you think? What is it that you would like the new policy for Developmental Services to address?
E-mail your comments contactus@dualdiagnosisontario.org. Your letters will also be posted on the Web Site.

Shelley Bishop writes:

On October 24, 2005 Dr. Yona Lunsky presented the findings of Phase II of her team's research on *Dual Diagnosis in Ontario's Psychiatric Hospitals* to a geographically diverse audience, with participants from Ottawa, Brockville, Kingston, Woodstock, London, Timmins and Kirkland Lake connected to the event via video and teleconference technologies. (See www.camh.net/pdf/dualdiagnosis_provpsychhosp_1styr2003.pdf for Phase 1 Report) Dr. Lunsky presented a series of recommendations to enhance treatment and support of individuals

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IN THIS ISSUE:

CHECK OUT OUR WEBSITE FOR WHAT'S NEW, GREAT LINKS AND RESOURCES:
http://www.naddontario.org
OR
http://www.dualdiagnosisontario.net

Update from the Board of Directors

This past Spring the Board reviewed and updated the organization vision statement and goals for the coming year:

We envision a society wherein persons with an intellectual disability and mental health needs (dual diagnosis) and their families have full and equitable access to supports and services that promote and enhance their mental health and well-being.

The activities of the organization over the next year will focus on the following goals:

1. To develop resources that support advocacy for policies and systems of care in Ontario that meet the needs of individuals with a dual diagnosis, their families and providers.
2. To provide education workshops to increase access to information, knowledge and understanding.

Annual General Meeting

A successful half day with approximately 40 attendees heard Dr. Karen Baker speak on Behavioural Implications of Genetic Syndromes, the importance of achieving diagnosis, and reviewed common characteristics, strengths and challenges of 6 genetic syndromes.

2004 Financial Report

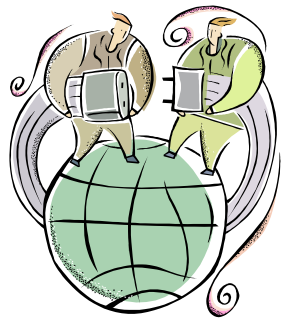
Balance at December 31, 2003		29,979
Income		
NADD Membership Rebate	3,032	
Training Manual Sales & Newsletter Subscriptions/	31,460	
Conference Income	620	
Interest	8	
Total	35,120	
Balance before expenses		65,099
Expenses		
Newsletter	881	
Board Expenses	4,223	
Training Manual Expenses	11,889	
Conference Expenses	1,620	
Insurance	1,080	
Web Site	199	
Total	19,892	
Balance at December 31, 2004		45,207

Interministerial News: Specialized Networks

Many reading this newsletter will be aware of the consultations that occurred this Fall to develop four Specialized Networks across the province. These networks will have three primary functions: to increase and improve service, coordination and capacity building for individuals with developmental disabilities and mental health problems and/or challenging behaviours. MCSS is congratulated for taking this leadership role in addressing a key element of the continuum of services that will contribute to community tenure. Here are some thoughts about the Networks:

1. The Networks should be based on a core group of providers who have a common understanding of "specialized". The role of these providers should be clearly distinguished from those of generic providers in relation to how such designated services commit and organize their clinical resources consistent with the best practices that have been established in guidelines and or in relation to multidisciplinary biopsychosocial assessment, treatment and care strategies. These specialized services would also have a history of continuing development and understanding of best practices in the context of literature, research and professional training.

2. The primary purposes of **service** and **capacity building** will often be in competition with one another for resources unless a clear and ongoing commitment is established. Within each Network reservation of a consistent and significant portion (e.g. no less than 25 or 30%) of funds for capacity building would ensure continuity over time, e.g., to be invested in an annual training calendar available across the region, curriculum development, the facilitation functions required with colleges and universities and research proposal writing. These decisions should be based on a strategic plan with set priorities for a 3 year period. The service portion of funds should also be strategically invested in local areas



to build upon and leverage the delivery of integrated and cross sector specialized resources.

3. The goal of building Specialized Networks should be to integrate and coordinate what currently exists, not to develop two mental health streams of specialized service. Currently, unlike any other province in Canada or State in the US, there exists a well developed continuum of specialized multidisciplinary outpatient and inpatient services for dual diagnosis operating out of nine psychiatric hospitals, some with university affiliation. Similarly, there are a number of Colleges and Universities within the province that have invested in capacity building in this field. The new Specialized Networks must develop and evolve in relation to such existing services and resources funded by the Ministries of Health and Colleges and Universities.

4. A system of four Networks across the province provides an important opportunity to establish a rational system at the local, regional and **provincial levels**. Currently there are a number of disparate groups, working toward very similar goals. This includes local dual diagnosis committees, the Ontario Chapter of NADD, and the Academic Health Science Centres Task Force on Developmental Disabilities. At various times MOHLTC and MCSS regional and provincial offices have funded various initiatives of these groups. The Networks now provide a rational means of bringing these groups into a coordinated and integrated whole at a provincial level.

For more information on Networks see the Here and There column in this edition.

Call for Partnership Ideas

Send us a one-page description of the 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. Send your description to contactus@dualdiagnosisontario.org

A Partnership in Action

In 2003, the Centre for Addiction and Mental Health Peel (Outpatient) Dual Diagnosis Service and both Associations for Community Living in Peel Region initiated discussions regarding how to increase understanding between their agencies. The purpose was to create an efficient procedure for deciding when to make psychiatric referrals, for communicating referral information, and to support the development of knowledge and skills of staff in their interactions with the mental health system. The outcome was formal referral procedures that outlined the roles of staff in each ACL and at CAMH.

Because of the size of the ACLs, it was agreed that each would designate two managers to be the referral coordinators (one each for the community and residential programs). They are the ones to work closely with CAMH community team intake staff. The role of the referral coordinators is to support and train ACL staff regarding the referral procedures. This includes how to identify appropriate referrals, why and how to complete the Peel Dual Diagnosis Referral Form, what to look for in reviewing the existing ACL file, and why and how to obtain consents/information releases. The result has been an increase in referrals to the CAMH multidisciplinary team.

In 2005 a plan was created for the secondment of ACL staff to CAMH for a four-month period. The Ministry of Health and Long Term care provided back-fill funding for the ACLs to support the plan.

The first secondment, of the referral co-ordinator from Brampton-Caledon Community Living, has been completed. Pam Lillos, Manager Community Living Supports worked full-time at CAMH, much of it directly with Karen McMillan, Social Worker, Peel Dual Diagnosis Service. They worked together on cases that were shared between the two agencies, including following a BCCL client from outpatient to inpatient admission.

Additionally, Pam attended inpatient and outpatient clinical meetings and interviews, co-lead a Therapeutic Social Skill group in the Day Treatment program, and attended in-house educational events. She successfully managed the secondment role, facilitating the work of her BCCL colleagues while resisting the temptation of doing their CAMH-related work for them! Pam also made new connections with a number of mental health providers in the Peel Region with whom she will collaborate in the future.

Pam reports that she now understands the multidisciplinary team process, the roles of different professions, and approaches to engaging with and interviewing families. She has returned to BCCL with a number of ideas regarding how to enhance the work that occurs within BCCL, such as how to flag individuals at risk for Dual Diagnosis, how to create/facilitate a collaborative inter-disciplinary team to serve them, how better to prepare for inter-disciplinary planning sessions, and how to implement bio-psycho-social recommendations for individual clients.

From CAMH's perspective, Pam fit into the team remarkably well. Her insights into individual clients and into the community were sought and integrated into clients' treatment plans. Overall Pam contributed as much as she benefited and her plan is to be a more pro-active contributor to the development of Dual Diagnosis capacity across both sectors (Developmental Services and Mental Health) in her region

For more information, contact Karen McMillan at 416-535-8501 ext. 2870 or Pam Lillos 905-453-8841 ext. 243

Local Committee Update

The Dual Diagnosis Implementation Committee of Toronto (DDICT) published a newsletter in September 2005. Here are some of the results of their work:

Pilot Project with Assertive Community Treatment Teams in partnership with Surrey Place Centre and the Dual Diagnosis Resource Service, (Centre for Addiction and Mental Health Toronto outpatient team). Five ACT teams identify cases at their intake stage. Surrey Place and DDRS staff work together to provide additional assessment, consultation or time limited service, in an effort to assist the decision making process of the ACT teams and to enhance care. The evaluation of this project was completed in October. It is now proposed to expand to all 12 ACT teams in Toronto.

Housing Guide developed and written with the financial support of the MCSS and MOHLTC and the Centre for Addiction and Mental Health. The Guide will be published in 2006 by CAMH on the web and a precis in hard copy. The Guide includes how to identify who has a dual diagnosis, the role of housing providers as part of the larger care system for clients with a dual diagnosis and how to navigate the system.

Ministry of Health and Long Term Care representation on the DS Sector Service Resolution Committee and Community Support Cluster began in 2003. This has facilitated communication of system level issues between the regional offices and supporting cross sector resolution of specific individual situations.

Dual Diagnosis Training Sessions facilitated by the DDICT – 2 sessions provided to the Developmental Sector Community Support Cluster on: Taking a Biopsychosocial Approach in Dual Diagnosis and Access to and Resources in Toronto.

Approximately 35% of individuals on the priority residential list in the Developmental Sector are identified as having a dual diagnosis. (February 2005) Between April 1, 2003 and March 31, 2004, 11 out of 42 (26%) new places to live were assumed by individuals with a dual diagnosis. Between April 1, 2004 and March 31, 2005, 12 out of 38 (32%) new places to live were assumed by individuals with a dual diagnosis. (Residential Data Base)

Here & There

Integrated Service Networks for people with serious mental health disorders – a timely article for Ontario regarding the Quebec Mental Health Services Networks: Models and Implementation," International Journal of Integrated Care (June 2005; 5:1-17) at www.ijic.org. The article reviews four models based on geographic region (rural, semi-urban, urban, and metropolitan) and integration strategies and the mandates required from government.

The Private Security and Investigative Services Act, Bill 159, is a bill to strengthen professional requirements for private investigators and security practitioners, sponsored by the Ministry of Community Safety and Correctional Services. Individuals with developmental disabilities, dual diagnosis and mental illness often come into contact with security personnel in various settings. The Psychiatric Patient Advocate Office prepared a submission to the provincial government's Standing Committee on Justice Policy, recommending all security guards take an examination following training, as well as undertake annual certification. The PPAO also recommends specific training modules for mental health, patients' rights, non-violent crisis intervention and other courses to minimize the risk of force with mental health consumers. For the PPAO's complete submission, see www.ppao@gov.on.ca

Funding Increases for Community Mental Health and Addiction Services were announced in July 2005 by the Ministry of Health. $53.8 million in 2005/2006 is directed towards mental health services including case management, crisis response, early intervention, assertive community treatment teams, and supportive housing as well as increased funding for addiction services, including withdrawal management, residential support and community counselling for community mental health and addiction services. These additional funds are the result of the Federal Government Health Accord agreement. The goal of the funding is to improve services for 34,000 Ontarians this year. For more information: www.health.gov.on.ca, July 14, 2005 "Expanding Community-Based Health Services".

continued from page 1

with dual diagnoses and build a continuity of service between in-patient and community settings, crossing inter-ministerial boundaries between the Ministry of Health and Long Term Care, and the Ministry of Community and Social Services. While many of the recommendations address systemic issues requiring cross-ministry collaboration at the Corporate level, concrete directions that can be achieved within current system structures at the regional level, through partnering between existing behaviour-analytic services and in-patient settings, were also suggested.

One such recommendation pertains to synchronizing models of care between in-patient and community settings for individuals presenting with aggression and challenging behaviour. Although aggression is diagnostically non-specific (Gardner, 2000; Sovner & Hurley, 1986), the presence of aggression in persons with dual diagnosis is often not only a precursor to hospitalization, but also a barrier to timely discharge (Lunsky et al, in press). Approaches for supporting individuals exhibiting aggression often vary between in-patient and community settings due to variants in resources, philosophies, and reliance on uni-dimensional approaches. In in-patient settings for example, there may be more reliance on containment procedures (chemical and physical restraints, locked settings), whereas containment approaches are often inadmissible in community settings, and there may be more reliance on behavioural approaches. An integrated approach based on a bio-psycho-social model which employs a multi-modal contextual analysis of the instigating factors, vulnerabilities, and maintenance variables contributing to aggressive and challenging behaviour, has shown to be more effective in producing positive outcomes (Charlot & Shedlack, 2002; Gardner, 2000; Griffiths & Gardner, 2002; Griffiths, Gardner & Nugent 1998). If integrated, comprehensive treatment approaches were implemented across settings, individuals with dual diagnosis who require hospitalization could move more fluidly through discharge and return to their communities sooner (Lunsky et al (in press).

The first step is to *acknowledge* the existence of non-synchronized models of care for aggression as an issue. Then *evaluation* of whether uni-dimensional or non-integrated approaches currently exist in our respective settings, followed by *priority setting* and *commitment* to multi-modal contextual functional analysis of aggression for each individual exhibiting aggressive behaviours, *initiating* a cross-sectoral alliance specific to this objective for continuum of care, and *accessing* dual diagnosis /multi-disciplinary clinical teams to *implement* training for stakeholders along a continuum of care to reframe services within an integrated biopsychosocial model.

This requires *a functional analysis* for each client with target behaviour, development of *individual treatment plans* based on functional assessment findings, *mediator training* for each treatment activity where indicated, *monitoring of outcomes* using objective data collection methods, *evaluation and revision of plans* based on clinical indicators, and *promotion of continuing partnerships* through ongoing training and consultation. Throughout Ontario there are a number of specialized, multi-disciplinary teams with clinical expertise in integrated bio-psycho-social approaches (King, 2005). In addition, MCSS is facilitating the development of four Specialized Networks across the province which may provide the context for these activities and the communication mechanism regarding effective approaches. Synchronizing models of care between in-patient and community settings for treatment of aggression appears to be a concrete and achievable goal. Let us begin, and accept Dr. Lunsky's challenge to create a province-wide initiative with commitment to broaden current hospital treatment of aggression in persons with dual diagnosis, to increase access to specialized clinical services in the community, and broaden training opportunities across sectors.

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Information Resources

http://www.ontario.cmha.ca/content/reading_room/policydocuments.asp?cID=6193
Ontario CMHA response to the Health Professions Regulatory Advisory Council regarding potential regulation of psychotherapists and psychotherapy. They have recommended that the activities of psychotherapy be regulated through the creation of new legislation, but do not support regulating psychotherapy as a Controlled Act.

Do you want to join NADD?

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Web site: http://www.thenadd.org
Inquire about family, student, individual and organizational memberships. Cost is paid in U.S. dollars with 20% returned to support Ontario Chapter activities.