INTO THE COMMUNITY AT LAST?

Report of the
Special Project for Systems Integration
a joint project of the Royal Ottawa Health Care Group and CMHA Ottawa

REPORT #1:
ISSUES RELATING TO INDIVIDUALS WITH DUAL DIAGNOSIS

SEPTEMBER, 2008

Gerry Casey, M.S.W.
with the assistance of Lynnette Scobie

Into the community at last

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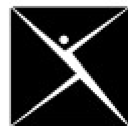
Centre de santé mentale
Royal Ottawa
Mental Health Centre



CANADIAN MENTAL
HEALTH ASSOCIATION
ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

EXECUTIVE SUMMARY

The Special Project for Systems Integration was established by the Champlain Mental Health Network to assess the capacity of the current system of Ottawa based mental health services to facilitate the community placement of patients from specialized inpatient facilities who are ready for discharge. The findings and recommendations of the project are outlined in two reports: the first, this report, exploring the unique dynamic faced by those with dual diagnosis and the extent to which appropriate, specialized, and adequate services are accessible and integrated between the developmental and health/mental health sectors; and the second, entitled *Report #2 Issues Relating to the General Population of Individuals with Severe and Persistent Mental Illness*.

Dual diagnosis refers to the presence of a psychiatric diagnosis and/or serious behavioural difficulty in a person with an intellectual disability. The Special Project for Systems Integration conducted extensive research and consultations with stakeholders to develop a general profile of individuals with dual diagnosis, to ascertain best practices for the community integration of individuals with dual diagnosis, and to identify systems issues, in the Ottawa context, that challenge the community integration of individuals with dual diagnosis.

The profiling component of the research revealed a full range of cognitive impairments, from mild to profound, among individuals with dual diagnosis. These impairments often combine with negative psychiatric symptoms to create complex deficits in adaptive functioning. These challenges are often further exacerbated by impairments in communication abilities. For the dually diagnosed, there is a high incidence of co-morbid health care issues, including physical disabilities and mobility impairments, and greater needs in terms of physical and medical support. As a result of their limited communication skills, pain and discomfort associated with medical conditions is often communicated through acting out behaviour, making appropriate identification of instigating symptoms difficult. Further, impulse control deficits and behavioural challenges often combine to create significant safety concerns in many settings. Inappropriate sexual acting out behaviour, often stemming from a lack of understanding of social and interpersonal norms, is common. Generally, functional skills in the activities of daily living and self-care are compromised, resulting in higher support and supervision needs.

A literature review of evidence based principles revealed that successful community integration of individuals with dual diagnosis requires integrated supports with flexible levels of service intensity and the capacity to develop and implement specialized and individualized care plans. Effective support mechanisms involve community based, specialized, residential treatment that has a strong rehabilitative component, combined and coordinated with intensive community support from multidisciplinary programs (such as dual diagnosis

consultation and outreach teams, intensive case management, and assertive community treatment) and backed up by community crisis bed capacity and short term crisis stabilization inpatient treatment, when required.

Most evident in the findings of the Special Project for Systems Integration was that current resources do not have the capacity to provide this level of service for the community integration of individuals with dual diagnosis. Primarily this is due to a complex weave of systems issues. Most pervasive is the split mandate for the provision of service and support for individuals with dual diagnosis across two provincial ministries: the Ministry of Health and Long Term Care (responsible for addressing the primary medical and psychiatric/mental health needs of individuals) and the Ministry of Community and Social Services (responsible for overseeing community integration related services for individuals with intellectual disability). This split mandate results in a lack of integration, communication, and specialized knowledge in programs that support the community integration of individuals with dual diagnosis. For example, community agencies within the developmental service sector do not have the expertise and resources to adequately address the challenges to community integration posed by the psychiatric and/or behavioural components of dual diagnosis. Similarly, generic mental health and medical interventions often lack expertise in intellectual disabilities and their interplay with psychiatric issues. Further compounding the issue is that the two ministries have separate budgets, planning processes, regulations, philosophies and service delivery structures.

Other key systems issues that challenge the community integration of individuals with dual diagnosis include:

- the lack of specialized inpatient care for individuals with dual diagnosis in generic tertiary care units and general hospital psychiatric inpatient services.
- the inability for existing specialized dual diagnosis units to prepare individuals for community integration or to transition individuals into community care when they are discharge ready.
- the lack of capacity within generic primary health services to adequately serve the complex needs of individuals with dual diagnosis and to modify clinical environments and procedures to address the unique needs of this population.
- the lack of specialized training and expertise in intellectual disability and dual diagnosis for primary health care staff and in psychiatric emergency response mechanisms.
- the lack of access to specialized dual diagnosis psychiatric emergency response interventions including mobile support, short-term crisis and respite bed capacity, and enhanced dual diagnosis capacity in hospital emergency rooms.
- the lack of specialized knowledge of dual diagnosis within intensive community support programs such as assertive community treatment and intensive case management or, when specialized programs do exist like the

ROHCG's Dual Diagnosis Consultation and Outreach Team, limited resources within these programs to address the overall need for specialized consultation.

Finally, the project identified the limited access to appropriate and sustainable community based residential services as a significant systems issue impacting the community integration of individuals with dual diagnosis. Residential treatment facilities, the most intensive level of community residential support, are not currently provided by either the developmental or health sector. Existing residential services and long term care facilities may be appropriate for some individuals with dual diagnosis. However, due to their limited capacity to provide specialized residential treatment, they have limited application for those with more complex mental health and/or behavioural concerns. Further, community residential supports funded through the Ministry of Community and Social Services transfer payment agencies have insufficient internal resources to train staff and serve individuals with complex physical, behavioural and psychiatric challenges. As a result, they lack the procedures and tools to address the needs of individuals with dual diagnosis. Also due to their limited resources, transfer payment agencies are unable to respond to the dramatic increase in referrals for service that will stem from the impending deinstitutionalization initiatives of both the health and development sectors.

Based on these findings, the Special Project for Systems Integration offers a number of recommendations for systems enhancements to address the limitations within the system. Paramount is the recommendation that the Champlain Mental Health Network facilitate inter-sector consultations and collaboration to address the needs of individuals awaiting community integration and to coordinate deinstitutionalization initiatives with existing levels of community support. Additional recommendations include initiatives to develop specialized programs or integrate knowledge of dual diagnosis into existing programs of community specialized inpatient care services, primary health care services, emergency/crisis services, community based tertiary care services, and housing/residential support systems. A number of the recommendations can be achieved through targeted initiatives within existing resources. Several of the recommendations, however, require the infusion of significant additional resources into the mental health system. Strong leadership and advocacy in implementing these recommendations on the part of service programs across the spectrum of mental health services is required to ensure that appropriate, specialized, and adequate services are accessible to individuals with dual diagnosis and integrated between the developmental and health/mental health sectors.

ACKNOWLEDGEMENTS

The Special Project for Systems Integration gratefully acknowledges and appreciates the participation of the many systems stakeholders, from both inpatient and community settings, who contributed to its process. The level of support received bodes well for future endeavors in *systems building.*

The Special Project for Systems Integration greatly appreciates the support and guidance of Dr. Pamela Prince, of the Royal Ottawa Health Care Group, in the completion of this report.

Finally, the Special Project for Systems Integration wishes to express its gratitude to the consumers, peer advocates and family members who participated in its activities. Their stories provided insight into the individual's journey of recovery and inspiration to work towards building a system of mental health services that supports that journey.

SUMMARY OF RECOMMENDATIONS

<table>
<tr><td>Closure of Institutional Care Settings Recommendations</td><td>That the Champlain Mental Health Network play a leadership role in facilitating multi-stakeholder, inter-sector consultations to explore advocacy and service planning initiatives with regards to the special needs of individuals awaiting community integration from health and developmental sector institutional settings.

Further, that consultation address the immediate service needs of individuals currently vying for community services, overall systems development issues, and avenues for advocacy regarding ministry mechanisms that impact on integrated service delivery. (p. 17)</td></tr>
<tr><td rowspan="3">Specialized Inpatient Care Recommendations</td><td>That the ROHCG continue to place a high priority on initiatives to enhance the biopsychosocial and community integration components of inpatient care in their dual diagnosis service. Service developments should proceed with a high degree of consultation and collaboration with community mental health and developmental sector stakeholders to ensure compatibility and integration of services. The Eastern Community Network of Specialized Care should be integrally involved with the ROHCG in the development and implementation of these collaborative initiatives. (p. 20)</td></tr>
<tr><td>That the Champlain Mental Health Network consult at the leadership level with developmental sector partners, including the Eastern Community Network of Specialized Care, to develop a plan to advocate for the continuance and enhancement of specialized dual diagnosis inpatient care capacity in the health care system. (p. 20)</td></tr>
<tr><td>That the Champlain Mental Health Network and the ROHCG explore strategies to better position the Brockville Mental Health Centre's dual diagnosis unit in the current system of specialized supports, and that intensive advocacy be engaged for the transformation and repositioning of this service rather than for its closure. (p. 20)</td></tr>
<tr><td rowspan="2">Primary Health Care Services Recommendations</td><td>That the Champlain Mental Health Network initiate consultations between health and developmental sector stakeholders to identify and engage concrete initiatives to enhance training in intellectual disabilities and dual diagnosis for existing primary health care staff and advocate for the inclusion of relevant content in the education programs for medical and allied health professions. (p. 24)</td></tr>
<tr><td>That concrete initiatives be taken to facilitate the enhancement and modification of primary health care clinical processes and protocols to better address the needs of individuals with intellectual disabilities and/or dual diagnosis. (p. 24)</td></tr>
</table>

Emergency/ Crisis Services Recommendations	That the Champlain Mental Health Network initiates inter-sector consultations to facilitate adaptations to hospital-based psychiatric emergency services to meet the special needs of individuals with intellectual disabilities and/or dual diagnosis. Further, that these consultations explore mechanisms to enhance access to comprehensive primary medical and psychiatric services in hospitals above and beyond emergency related treatment. (p. 26)
	That the Champlain Mental Health Network consult and collaborate with the Eastern Region Community Network of Specialized Care in the ongoing development of the Network's Crisis Prevention and Intervention Program. (p. 28)
Community Based Tertiary Care Recommendations	That the Champlain Mental Health Network initiate consultations between health/mental health and developmental sector stakeholders, to advocate for the enhancement of specialized dual diagnosis community consultation services, and that these consultations include the input of the DDCOT, CMHA DD Clinic, OCTC Behavioural Services, Community Networks of Specialized Care, and other stakeholders with which these services have formed linkages. (p. 31)
	That the Champlain Mental Health Network engage in consultations with the Eastern Region Community Network of Specialized Care to ensure that health sector intensive community support programs play an active, consultative, and collaborative role in the ongoing development of specialized services being undertaken by the Network, and that these consultations explore mechanisms to ensure inter-sector integration of specialized, intensive community support services. (p. 34)
Housing/ Residential Supports Recommendations	That the Champlain Mental Health Network place a high priority on advocating for the development of a residential treatment facility within the current system of specialized community supports available to individuals with dual diagnosis. (p. 36)
	That the Champlain Mental Health Network initiate cross-sector consultations to explore the capacity of long-term care facilities to meet the needs of individuals with dual diagnosis and that these consultation explore the efficacy of this model with regards to its application across the spectrum of complex needs, with a view to identifying mechanisms to enhance specialized services for those situations where long-term care is deemed appropriate. (p. 37)
	That the Champlain Mental Health Network collaborate with developmental sector stakeholders, including transfer payment agencies and the Eastern Region Community Network of Specialized Care, to advocate, at the Ministry level, for enhanced human resources funding and training resources for community residential care programs. (p. 39)
	That the Champlain Mental Health Network collaborate with developmental sector stakeholders, including transfer payment agencies and the Eastern Region Community Network of Specialized Care, to identify strategies to maximize access to specialized dual diagnosis training, within existing resources, for community residential programs. (p. 39)

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LIST OF ABBREVIATIONS

ACTT	Assertive Community Treatment Teams
BMHC	Brockville Mental Health Centre
CMHA	Canadian Mental Health Association
CMHA Ottawa	Ottawa Branch of the Canadian Mental Health Association
CMHN	The Champlain Mental Health Network
CPIP	Crisis Prevention Intervention Program
DD Clinic	CMHA's Dual Diagnosis Community Clinic
DDCOT	Dual Diagnosis Consultation Outreach Team (of the Royal Ottawa Hospital)
FAWG	Family Advisory Working Group (of the Champlain Mental Health Network)
ICM	Intensive Case Management
LHIN	Local Health Integrated Networks
MHCSS	Mental Health Community Support Services
OCTC	Ottawa Children's Treatment Centre
ODSP	Ontario Disability Support Program
OMCSS	Ontario Ministry of Community and Social Services
OMHLTC	Ontario Ministry of Health and Long Term Care
ROHCG	Royal Ottawa Health Care Group
ROMHC	Royal Ottawa Mental Health Centre
SSAH	Special Services at Home

INTRODUCTION

The recent announcement of the newly created Mental Health Commission of Canada brought significant, though short lived, media attention to the reality faced by individuals with mental illness in Canadian society. The Commission was born from recommendations of Senator Kirby's "Out of the Shadows at Last", and his national study on mental health, mental illness, and addictions (Senate, 2006). The Commission was established to bring national leadership to the development of an integrated mental health system that places people living with mental illness at its centre. For the special population of Ontarians who have been dually diagnosed with an intellectual disability and mental illness, the idea of an integrated system of supports is an alien concept. Over the past three decades, individuals with dual diagnosis have sought services through two distinct systems of support: the health/mental health sector to address their physical and mental health needs and the developmental sector for supports relating to their intellectual disability. Service provision to these individuals is marked by the lack of integration and collaboration between the two sectors and the lack of capacity of either sector to provide specialized and individualized service. Essentially, there is no 'centre' in the current landscape of services where individuals with a dual diagnosis can be placed.

> ***"For the special population of Ontarians who have been dually diagnosed with an intellectual disability and mental illness, the idea of an integrated system of supports is an alien concept."***

Service delivery paradigm shifts in the health and developmental sectors are moving toward de-institutionalization and community integration for individuals with dual diagnosis. The concepts of integrated, individualized and specialized community supports are defining principles in this philosophy of change. Access, or lack of access, to appropriate, adequate, flexible, accessible, individualized and integrated services can support or confound the recovery process for individuals with dual diagnosis. If these individuals are to come out of the shadows and into the community at last, the systems that support their integration will need to better reflect evidence based principles of practice. There are significant opportunities in the current systems dynamic to pursue this paradigm shift.

The Special Project for Systems Integration was established by the Champlain Mental Health Network to assess the capacity of the current system of Ottawa based mental health services to facilitate the community placement of patients from specialized inpatient facilities who are ready for discharge, including the special population of individuals with dual diagnosis. Its scope of inquiry examined the extent to which services are appropriate, adequate, and integrated

across the health/mental health and developmental sectors. The project initiated extensive consultations with professional stakeholders, consumers, and family members to identify systems issues that confound the process of community integration for individuals with dual diagnosis and to make recommendations for operational improvements. These findings and recommendations are outlined in two summary reports: this report, exploring the unique dynamic faced by individuals with dual diagnosis, and a second report addressing issues relating to the more general population of individuals with severe and persistent mental illness. Some of the recommendations identified by the Special Project for Systems Integration can be achieved within existing resources. Most, however, require the infusion of significant additional resources into the support system. Many of the findings and recommendations have previously been identified in national and provincial studies and in policy documents but they have yet to be integrated into the system. Strong leadership and advocacy in implementing these recommendations on the part of service programs across the spectrum of mental health services is required to ensure that appropriate, specialized, and adequate services are accessible to individuals with dual diagnosis and integrated between the developmental and health/mental health sectors.

FORMAT OF THE REPORT:

This report, submitted to the Systems Table of the Champlain Mental Health Network, is organized as follows:

- **Executive Summary**: providing a general overview of the purpose, scope, and findings of Special Project for Systems Integration investigations.
- **Summary of Recommendations:** outlining all recommendations made and providing page number references to the location of these recommendations in the body of the report.
- **List of Abbreviations:** providing readers with a central reference list for the terms and acronyms used in the report.
- **Background:** providing background to the inception of the Special Project for Systems Integration and its goals.
- **Methodology:** outlining the project's methodology and scope.
- **Dual Diagnosis**: offering a summary of research and evidence based principles surrounding dual diagnosis and a discussion of the profile of individuals with dual diagnosis considered in this report.
- **Findings/Discussions**: discussing the findings of Special Project for Systems Integration investigations and recommendations for systems enhancements.
- **Appendices:** providing a detailed overview of the data gathering activities of the Special Project for Systems Integration, templates of all the data gathering tools developed by the project, and a list of the evidence based research reviewed by the project.

BACKGROUND

THE CHAMPLAIN MENTAL HEALTH NETWORK AND MENTAL HEALTH REFORM

The Local Health Integrated Networks (LHIN) were created by the Ontario government in 2006 as not-for-profit corporations to work with local health providers and community members to determine health priorities in their identified districts. The Champlain Mental Health Network (CMHN) is charged with planning, coordinating, and making funding recommendations to the Ontario Ministry of Health and Long Term Care (OMHLTC) related to addictions and mental health services in the Champlain LHIN district. The membership of the Champlain Mental Health Network represents a wide range of system stakeholders. Its structure includes focus-specific work groups and a Systems Table, comprised of representatives from the work groups, that provides overall guidance and direction to the Network.

The Champlain Mental Health Network's mission statement commits to "working in partnership with mental health related networks to ensure the mental health system is a client-centered, recovery-based continuum of services that provides hope and dignity while improving the health and service satisfaction of the residents of the Champlain District" (CMHN, 2006, p. 1)**.** CMHN's objective to strengthen the mental health system is guided by the principles of full and equitable representation and participation of consumer, family, and service provision stakeholders. Its activities include advocating at a systems level; supporting evaluation, education and capacity building; identifying systems-wide needs and service gaps; and investigating innovative models that build on strengths and promote linkages among organizations, enhance communication and information sharing and develop links to facilitate service coordination and integration (CMHN, 2006).

The Champlain Mental Health Network has identified the following five high level priorities for systems development:

- A LHIN-wide recovery-oriented mental health system, honoring choice, self-determination and addressing the determinants of health, across the life span;
- Streamlined, coordinated access to an integrated system of services that welcome individuals and assist the consumer and their network to find and obtain (receive) appropriate services;
- Access to a continuum of suitable and affordable housing with the necessary support services to promote the retention of housing;
- The full continuum of services for special populations (dual diagnosis, concurrent disorders, geriatric psychiatry, borderline personality

disorders, forensic) reflecting best practices and designed for special needs;
- Formal advocacy mechanisms to address individual, policy and system-wide issues (CMHN, 2006).

CMHN considers the integration of services and system components to be a key factor in determining the capacity of the mental health system to support the community placement of individuals with serious and persistent mental illness. Integration implies coordination and collaboration between the wide variety of agencies and organizations that serve people with mental illness. It also implies that services are available and adequate to meet all needs (CMHN, 2006).

“Integration implies coordination between the wide variety of agencies and organizations that serve people with mental illness. It also implies that services are available and adequate to meet all needs.”

THE SPECIAL PROJECT FOR SYSTEMS INTEGRATION

The Special Project for Systems Integration emerged from discussions at the CMHN Systems Table regarding systems integration issues that impact the community placement of patients in specialized inpatient facilities who are ready for discharge and awaiting alternate levels of care. Informing the goals and scope of the Special Project for Systems Integration were discussions highlighting the challenges faced by the Royal Ottawa Health Care Group (ROHCG) in transitioning patients with severe and persistent mental illness, including the special population of individuals with dual diagnosis, from its inpatient units into Ottawa based community placements. Adopting CMHN's key principles and priorities for system development as a foundation, the Ottawa Branch of the Canadian Mental Health Association (CMHA Ottawa) and the ROHCG assumed a leadership role in the development of the Special Project for Systems Integration. CMHA Ottawa and the ROHCG each seconded a staff member to act in the capacity of co-leads for the one-year pilot project, which was launched in October, 2006. The co-leads were supervised by members of the senior management of both the ROHCG and CMHA Ottawa. The project supervisors provided a direct link to the CHMN Systems Table and all project activities were vetted through, and guided by, the Systems Table.

The co-leads were charged with developing mechanisms to engage in consultations with key stakeholders and with completing reports identifying strengths, gaps, and opportunities related to service integration and the capacity of the current mental health system to facilitate community integration of individuals with severe and persistent mental illness. The scope of inquiry for the project was limited to the Ottawa based mental health service system. Activities were focused on exploring issues that impact the capacity of the mental health system to facilitate transitional planning and community

integration for individuals within its target populations, not on individual discharge planning.

The target populations for the project were individuals with severe and persistent mental illness receiving ROHCG inpatient care and/or intensive community based supports, including the special population of individuals with dual diagnosis. From the outset, the Special Project for Systems Integration recognized that individuals with dual diagnosis face unique challenges in pursuing community integration. These challenges stem from diagnostic factors that are distinct to dual diagnosis and from unique systems dynamics that impact service provision and access criteria for individuals with dual diagnosis. Hence, the Special Project for Systems Integration developed specific data gathering tools, and consulted with specific stakeholders in the developmental and health/mental health sectors to aid its investigation of the capacity of the mental health system to address the unique challenges faced by individuals with dual diagnosis. Particular focus was placed upon the extent to which the present configurations of services facilitate the community placement and support of individuals receiving inpatient treatment through the ROHCG dual diagnosis service.

DUAL DIAGNOSIS AND MENTAL HEALTH REFORM

Provincial and Champlain LHINs have identified, as a priority for mental health reform, the need to enhance specialized services for individuals with dual diagnosis. Dual diagnosis refers to the presence of a psychiatric diagnosis and/or serious behavioural difficulty in a person with an intellectual disability. Individuals with intellectual disabilities experience the same range of psychiatric illness as do those who do not have intellectual disabilities. Although the incidence of psychiatric illness in this population is often under-diagnosed, it is three to four times more common than in the general population (Lunsky et al., 2003; OMCSS & OMHLTC, 2005). Challenging behavioural disorders including physical and verbal aggression directed towards others and self-injurious, destructive, and stereotyped behaviours are particularly prevalent in individuals with intellectual disabilities. Their occurrence presents significant challenges to the process of diagnosing psychiatric illness (DCP, n.d.). Individuals with dual diagnosis often have communication and thought process deficits that impair their ability to report symptoms. As a result, clinicians must distill symptomatic features that may have neurobiological, primary medical, psychological or social/environmental causes from third-party reports of behavioural presentations. The reliance on behavioural presentations makes accurate isolation of psychiatric symptoms difficult. There is a risk of diagnostic overshadowing, whereby symptoms are over-attributed to intellectual disabilities rather than to the psychiatric disorder. Alternatively, challenging behaviours may be over-attributed to psychiatric conditions (DCP, n.d.).

The presence of both an intellectual disability and a psychiatric illness has a negative impact upon the individual's adaptive functioning and, as a result,

community integration requires significant support. With the complex interplay of neurobiological, primary medical, psychological and social/environmental factors in individuals with dual diagnosis, diagnosis and treatment require multi-disciplinary, multi-dimensional systems of assessment and support that account for all domains of the individual's functioning. This multi-modal approach to assessment and treatment is referred to as a biopsychosocial approach as it considers physical and psychiatric conditions, psychological characteristics, and environmental, social/interpersonal and program features in its diagnostic-treatment formulation (Griffiths, Gardner & Nugent, 1999; OMCSS &OMHLTC, 2005). Effective biopsychosocial assessment and treatment require systems of support that draw expertise from a wide range of settings that are highly integrated and coordinated. For individuals with dual diagnosis with the most complex and chronic psychiatric conditions, specialized tertiary supports are required.

The challenges faced by individuals with dual diagnosis in accessing integrated and specialized services are attributable to the structure of the systems within which these varied services operate, and how these structural dynamics determine the mechanisms through which needs are assessed and access to treatment is facilitated. The systems feature that has the most pervasive effect on the provision of integrated and coordinated care is the two separate provincial ministries mandated with supporting the needs of individuals with dual diagnosis. The two ministries are the Ministry of Health and Long Term Care (OMHLTC), responsible for the primary medical and psychiatric/mental health needs of this population; and the Ministry of Community and Social Services (OMCSS), responsible for the oversight of community integration related services for individuals with intellectual disabilities. The split mandate has produced barriers to integrated service development and delivery and has had significant implications for the community integration of individuals who have been dually diagnosed.

"The challenges faced by individuals with dual diagnosis in accessing integrated and specialized services are attributable to the structure of the systems within which these varied services operate and how these structured dynamics determine the mechanisms through which needs are assessed and access to treatment is facilitated."

Developmental services in Ontario evolved from segregated care in large institutional settings, under the auspices of the Ministry of Health, to integrating individuals and their supports into the community under the direction of the Ministry of Community and Social Services (OMCSS, 2006). This shift towards community based support and the transfer of ministry mandate was formalized in 1974 with the *Developmental Services Act*. The concept of community integration has further evolved under OMCSS to recognize the need to reduce barriers to full community participation and citizenship for

those with intellectual disabilities (OMCSS, 2004). In 1987, following the successful community placement of a significant number of individuals from institutional care, OMCSS announced a plan to close all of the institutions in Ontario within 25 years. A subsequent announcement in 2004 revised this timeline, stating that the three remaining institutions would close by March 31, 2009 (OMCSS, 2004). While OMCSS maintains responsibility for the oversight of the three remaining institutions, the focus of Ministry initiatives have been on the development of community based services to support the community integration of individuals with intellectual disabilities.

Developmental services under the purview of the OMCSS are delivered through a network of non-profit community based agencies that contract with and are funded by the Ministry. Access to services is coordinated regionally through central points of access. In the Ottawa region, Service Coordination provides this function. The services funded by OMCSS include residential supports (group living residences, care in 'host' family homes, and supported independent living), respite support (day and overnight support to families and primary caregivers), community participation supports (day activity and recreation supports, vocational supports and other community participation programming), and specialized services to address special needs (assessment and counseling services, speech and language programs, and behavioural assessment and treatment programs) (OMCSS, 2006). Most adults with an intellectual disability receive income support under the Ontario Disability Support Program (ODSP). The Special Services at Home (SSAH) program also provides funding to qualifying individuals and/or their families to purchase supports that are not otherwise provided elsewhere in the community (OMCSS, 2006).

While the community integration service needs of individuals with intellectual disabilities are provided for through the OMCSS, the Ministry of Health and Long Term Care (OMHLTC) provides for their primary medical and mental health care needs. Primary health care interventions, including access to general practitioners and dentists, general hospital inpatient and outpatient treatment, emergency medical interventions, and specialized medical procedures are accessed through the medical system available to the larger populace (generic health care system). For those with ongoing complex medical needs, both in-home support and nursing home care is also accessed through the generic system. Similarly, the mental health needs of individuals with intellectual disabilities are served through the generic mental health care system funded by OMHLTC. Services include psychiatrists, general hospital psychiatric units, long-term care facilities, community mental health programs and Homes for Special Care. OMHLTC also funds provincial psychiatric hospitals (including those with specialized dual diagnosis units); however, in 1996, the Health Services Restructuring Commission recommended that all provincial psychiatric hospitals, including the Brockville Psychiatric Hospital and its dual diagnosis inpatient unit, be closed with no concrete indication of where alternative services would be accessed.

The split mandate between the OMCSS and the OMHLTC has created significant barriers to specialized and coordinated services for individuals with dual diagnosis. These barriers present within the range of services provided by each ministry and in terms of the linkages between the two sectors. Community agencies within the developmental sector do not have the expertise and resources to adequately address the challenges to community integration posed by the psychiatric and/or behavioural components of dual diagnosis. Similarly, generic mental health and primary health interventions often lack expertise in intellectual disabilities and their interplay with psychiatric issues. Each sector has, to some extent, developed specialized services and mechanisms to address these issues and these initiatives are addressed in more detail later in the report. It remains, however, that at many levels each sector defers to the other for service provision with the result being that the individual with dual diagnosis receives comprehensive service from neither (Lunsky et. al., 2003).

Further compounding the issue of lack of sector expertise in the elements of dual diagnosis is that the two ministries have separate budgets, planning processes, regulations, philosophies and service delivery structures (Lunsky et. al., 2003). Historically, developments in service delivery in each sector have proceeded with limited consultation and collaboration. Although there are isolated examples of service protocols between agencies from both sectors, this is not represented in the system at large. Inter-agency communication is not well established resulting in a limited capacity for individuals with dual diagnosis to access a seamless continuum of services across sectors. Furthermore, eligibility criteria are unclear within each sector and inconsistent between sectors. For instance, the existence of an intellectual disability in an individual with significant behavioural problems often constitutes a 'dual diagnosis' for the purposes of access to specialized services in the developmental sector, while access to specialized primary health/mental health supports often requires a distinct Axis I psychiatric diagnosis in the medical sector (Lunsky & Puddicombe, 2005). In both sectors, access criteria are inconsistently applied from one program to the next, leaving individuals and care providers unclear as to what services are available.

In 1997, OMCSS and OMHLTC jointly released the *Policy Guideline for the Provision of Services for Persons with a Dual Diagnosis* recognizing the systems barriers faced by individuals with dual diagnosis, the joint responsibility for this population, and the need for coordinated inter-ministerial approaches to systems development and service delivery (OMCSS & OMHLTC, 1997). To date there has been limited success in operationalizing the principles of this policy document. Most significant are the lack of access to integrated services and the continued lack of cross-sector collaboration in rectifying these concerns. This is perhaps best exemplified by the lack of inter-sector collaboration surrounding de-institutionalization. The phase out of institutions, such as the Rideau Regional Centre in Smiths Falls by the OMCSS and the closure of provincial psychiatric hospitals, such as the Brockville Psychiatric Hospital (which includes a dual diagnosis inpatient unit) by the OMHLTC are not coordinated across the sectors

or in tandem with other resources. This compounds the challenges already inherent in the system for individuals with dual diagnosis in terms of access to scarce specialized resources.

For the individual with a dual diagnosis, the challenges to community integration presented by their intellectual and psychiatric conditions are exacerbated by a range of systems issues that impact on service delivery. This state of affairs is well recognized in both research and in policy documents, as are potential measures to rectify the situation. What is lacking is a comprehensive application of the identified corrective measures. This has significant implications for the capacity of Ottawa based services to support the community placement of individuals with dual diagnosis receiving specialized inpatient care through ROHCG services.

METHODOLOGY

The Special Project for Systems Integration conducted a range of consultations and information gathering activities to identify strengths, gaps, and opportunities for service integration, transitional planning, and the capacity of the current Ottawa-based mental health and developmental service systems to facilitate the community placement of targeted populations, including individuals with dual diagnosis.

CMHN's five high-level priorities, mission, objectives and principles informed all aspects of the Special Project for Systems Integration's activities. The project was also informed by evidence based principles in discharge/transitional planning and community based service provision to individuals with severe and persistent mental illness and individuals with dual diagnosis. Evidence based principles are practices and recommendations based on scientific knowledge, clinical experience and expert consensus.

The Special Project for Systems Integration undertook extensive research to identify issues relating to mental illness, dual diagnosis, and transitional planning and community integration. This included a review of documents regarding evidence based principles and key quality indicators in transitional/discharge planning, service integration, community support of individuals with serious and persistent mental illness, homelessness and mental illness, and the provision of support to individuals with a dual diagnosis. It also included a review of policy documents regarding mental health and developmental services reform in the national and provincial contexts.

The project also initiated a range of activities to develop a general profile of individuals with severe and persistent mental illness and individuals with dual diagnosis. These activities included chart audits, interviews with inpatient social workers and community partners, and participation in multi-stakeholder case conferences regarding individuals with complex needs. This component of the research identified diagnostic and symptom factors relevant to the target population and their implications in terms of treatment and service needs, challenges to community placement, and risks of re-hospitalization. It revealed a composite profile of the individual characteristics and complex needs that present the most significant challenge to community integration initiatives for individuals with severe and persistent mental illness and dual diagnosis.

The Special Project for Systems Integration's exploration of mental health and developmental service systems issues involved consultations with a range of consumers, advocates, and service providers. Information was gathered through a combination of interviews, questionnaires, focus groups, and participation in existing meetings, case conferences, and committee activities. Inquiries included consultations with professional stakeholders who provide discharge planning,

service coordination and brokerage, intensive case management and community support, residential care and other community based services. Interviews and questionnaires with consumer and family advocates and consumer focus groups were also performed. The focus of these consultations was to gain insight on discharge and transitional planning, information exchange, service provision and integration, access criteria for specialized services, capacity within the system and individual programs to address complex needs, and the extent to which consumers and family members are engaged as full participants in the treatment process. The consumer focus groups were developed in consultation with the Client Empowerment Council of the Royal Ottawa Mental Health Centre (ROMHC) and Psychiatric Survivors Ottawa. A detailed listing of the groups and individuals consulted by the Special Project for Systems Integration is included in Appendix A.

The Special Project for Systems Integration developed a number of tools to facilitate its information gathering activities. These included, among others, a *Chart Audit Tool*, *Residential Caregiver Interview Tool*, *Developmental Services Residential Caregiver Interview Tool*, *Consumer Focus Group Tool*, *Family Questionnaire*, *Community Support Program Interview Tool*, *Community Based Support Worker Questionnaire* and a *Social Work Staff Questionnaire*. The development of these tools was informed by evidence based research and the mental health reform priorities that guided the project. Templates of all of the tools developed by the Special Project for Systems Integration are included in Appendix B.

SCOPE AND LIMITATIONS

The parameters of the project precluded the exploration of systems issues outside of the Ottawa region. As a result, there are significant issues impacting rural mental health services that did not fall within the Special Project for Systems Integration's scope of inquiry. As well, the project did not have access to services and programs within the general hospital system. Thus, ROHCG staff consultations were limited to social workers, patient representatives and patient advocates/rights advisors, and intensive community support and consultation programs.

The Special Project for Systems Integration explored general systems issues that have an impact on service provision to individuals with severe and persistent mental illness and, for this report, individuals with dual diagnosis. Within these populations there are many sub-groups of individuals with unique needs that did not receive distinct attention. The unique challenges faced by the geriatric and transitional youth populations, individuals with forensic involvement, individuals from francophone, aboriginal and other cultural groups, and a number of other distinct groups within the dually diagnosed spectrum did not receive focused exploration.

PROJECT TARGET POPULATION

The Special Project for Systems Integration initiated a range of activities to develop a general profile of individuals with dual diagnosis who present the most significant challenges to community integration and who are at the highest risk for placement breakdown and hospitalization. These activities included chart audits and consultations with inpatient social work staff regarding individuals receiving services through ROHCG dual diagnosis inpatient treatment. They also included a range of consultations with stakeholders from both the developmental services and health/mental health care sectors to identify both demographic and systems issues. The profiling process also included a review of the Lunsky and Puddicombe reports related to the treatment of this population in Ontario's specialty hospitals (Lunsky et al., 2003; Lunsky & Puddicombe, 2005). These reports offered a detailed quantitative and qualitative overview of patient demographics, symptom profiles, strengths and resources, and level of care required, as well as insight into the systems issues that impact upon inpatient and community based service delivery. The composite profile identified by the Special Project for Systems Integration included individuals in both specialized and generic hospital inpatient care and those living in a range of community settings including family homes, independent living environments, Homes for Special Care, group homes, and boarding home situations.

The purpose of developing a representative profile was not to present individuals with dual diagnosis as a homogeneous group. Indeed, as Lunsky et al. point out, there are as many differences within this group as there are commonalities (Lunsky et al., 2003). What is common for individuals with dual diagnosis is a range of predisposing, precipitating, and perpetuating risk factors that impact the individual's capacity to function effectively in community settings. These risk factors include physical factors that are genetic, medical, and neurobiological in origin; cognitive factors that relate to psychological functioning and coping skills; and social factors that relate to the interplay between social and physical environmental features (Lunsky et al., 2003). The acuity of these risk factors and the extent to which services are available to assist individuals in mediating their effects are determining factors for successful community integration. Perhaps the one consistent commonality for this population is the lack of access to individualized, coordinated, and integrated cross-sector care, and the impact that systems dynamics have on their ability to exercise their rights to community participation and integration. In many cases service delivery issues play a greater determining role in the failure to support community integration than do individual functional and diagnostic characteristics.

Although many individuals with dual diagnosis can function effectively in community settings with limited supports, there is a sub-population whose complexity of needs create barriers to integration and who require flexible levels

of specialized treatment and support. The Special Project for System Integration identified a consistent constellation of individual diagnostic characteristics and the manner in which they interplay with service delivery dynamics that pose significant challenges to community integration and the provision of appropriate treatment and support. This general profile was consistent with that presented in the current literature. The extent to which these characteristics and treatment dynamics are present varies from individual to individual and from one period of time to the next.

The constellation of characteristics identified by the Special Project for Systems Integration as most indicative of challenges to community functioning emerge from various factors relating to developmental, psychiatric, and treatment domains. Individuals with dual diagnosis receiving specialized dual diagnosis treatment, in either inpatient or outpatient settings, present with higher reported symptom severity, greater needs, and fewer resources than individuals with an intellectual disability or mental illness alone who receive treatment through generic services (Lunsky et al., 2003). Psychotic disorders, mood disorders, anxiety disorders, and personality disorders are reported in individuals with intellectual disabilities at rates higher than in the general population, although there are reported issues regarding potential over-diagnosis of psychotic disorders and under-diagnosis of mood and anxiety disorders (Lunsky et al., 2003). A significant percentage of this population is treated with psychotropic medications. There is a full range of cognitive impairments, from mild to profound, represented in this population, and these impairments often combine with negative psychiatric symptoms to create complex deficits in adaptive functioning. These challenges are often further exacerbated by impairments in communication abilities.

"Perhaps the one consistent commonality for this population is the lack of access to individualized, coordinated, and integrated cross-sector care, and the impact that system dynamics have on their ability to exercise their rights to community participation and integration."

For this population, impulse control deficits and behavioural challenges, which can include physical and verbal aggression directed towards others, self-harm behaviour, property damage, and other high risk behaviour such as fire setting, often combine to create significant safety concerns in many settings. As skills in maintaining personal safety are often lacking, this population is particularly vulnerable to wandering, injury, and incidents of abuse in unsupervised settings. Inappropriate sexual acting out behaviour, often stemming from a lack of understanding of social and interpersonal norms, is common. Functional skills in activities of daily living and self-care are often compromised resulting in higher support and supervision needs. Incontinence is a common concern. There is a high incidence of co-morbid health care issues, including physical

disabilities and mobility impairments, and greater needs in terms of physical and medical support. As a result of limited communication skills, pain and discomfort associated with medical conditions is often communicated through acting out behaviour, making appropriate identification of instigating symptoms difficult.

This general profile represents a diverse population of individuals whose individual constellation of characteristics present significant challenges to community placement. The general failure to adequately support the integration of this population is not, however, a result of the complexity of their needs alone. Lunsky and Puddicombe (2005) found that only 12 percent of patients with dual diagnosis in provincial psychiatric hospitals required the inpatient care they were receiving. The majority of care should be provided in community settings. However, community based programs not only lack the highest levels of service intensity, but also the capacity to care for individuals with much more moderate needs. Currently, in the Ottawa context, 37 percent of dually diagnosed inpatients have been in hospital for more than five years: many are there simply because appropriate community supports are not available (Lunsky et al., 2003).

FINDINGS/DISCUSSION

The Special Project for Systems Integration was tasked with exploring the issues relating to the community integration of individuals with dual diagnosis receiving inpatient treatment through the ROHCG Dual Diagnosis Service. The findings indicate that the community integration of this special population requires integrated supports with flexible levels of service intensity and the capacity to develop and implement specialized and individualized care plans for those with the most complex needs. The levels of support required involve community based, specialized, residential treatment that has a strong rehabilitative component. It should be combined and coordinated with intensive community support from multidisciplinary programs such as outreach consultation teams, intensive case management, and assertive community treatment. When required, it should also be backed up by community crisis bed capacity and short term crisis stabilization inpatient treatment (Lunsky & Puddicombe, 2005). Current resources do not have the capacity to provide this level of service. This is not because the care needs of the target population are beyond what evidence based principles suggest community based care should be able to accommodate. The required capacity has simply not been developed due to a complex weave of systems issues including the dual ministry dynamic that underlies service provision for individuals with dual diagnosis and the resulting lack of integrated and coordinated specialized services. In this section, we explore how this dynamic is played out in the current service system and offer potential avenues to rectify the situation.

CLOSURE OF INSTITUTIONAL CARE SETTINGS

The impending closure of developmental and health care sector institutional settings most prominently reveals the lack of coordination between the two sectors serving the dually diagnosed. The OMCSS is in the process of discharging any remaining residents from its schedule one facilities, including the Rideau Regional Centre in Smiths Falls, scheduled for closure in 2009. The OMHLTC is engaging in a simultaneous process of divesting its programs and services from provincial psychiatric hospitals, including the Brockville site of the ROHCG, to public hospitals and community mental health programs. The combined population of these two institutional settings represents a significantly high needs group.

The remaining residents of Rideau Regional Centre have complex needs that will require significant community integration support. A 2005 survey of the residents, included in briefings for the class action legal challenge to the closure of the provincial institutions, provides insight into the complexity of these individuals' needs (OSCJ, 2006). Their average age is 54 years and the average length of stay at the Centre is 39 years**.** Over 300 of the residents are profoundly

developmentally delayed, with 90 of them in the severe category and a significant number suffering from various stages of Alzheimer's disease and other forms of dementia. Many individuals have a dual diagnosis. More than 200 residents are prone to self-abuse and more than 240 are physically aggressive, posing a risk to others. Few have significant verbal skills. Seventy five percent suffer from chronic long-term physical disabilities and almost half require assistance with most, if not all, of their daily living activities. The community support needs of these individuals, combined with those of the individuals being released from Brockville's dual diagnosis inpatient unit (see below), create enormous pressure on available resources.

According to systems stakeholders, community resources are not adequate to accommodate the influx of special needs individuals from these institutional settings. They also believe that ongoing service developments have not been informed by adequate collaboration between the developmental and health/mental health sectors. Each sector is attempting to enhance capacity to serve the individuals being discharged from their respective institutions, but these initiatives have progressed largely in isolation. This lack of collaboration results in a loss of opportunities to share knowledge and resources and to engage in joint planning to develop efficient and responsive community support services for those seeking community integration. While there is support for collaboration and consultation from program personnel in both sectors (and indeed inter-sector discussions have been ongoing at the program level), separate funding streams, service criteria and accountability mechanisms in each sector makes extensive joint planning difficult. For example, due to divergent funding mechanisms, most residents discharged from institutions under the direction of OMCSS have annualized funding designations for their community integration, while individuals discharged from provincial psychiatric hospitals such as Brockville's dual diagnosis inpatient unit do not. As a result, most of the capacity enhancements are undertaken by developmental sector community programs targeting individuals coming out of the OMCSS system.

Recent initiatives in the health/mental health and developmental sectors provide avenues to address these system dynamics. Increased involvement in community integration planning for ROHCG dually diagnosed inpatients by Service Coordination, Citizen Advocacy and CMHA Ottawa's dual diagnosis brokers has better positioned this population in the community service planning initiatives being undertaken for Rideau Regional Centre residents. Increased inter-sector consultation at the program leadership level is taking place and is resulting in increased advocacy for changes to ministry funding, access, and service delivery mechanisms. The OMCSS has recently launched "Community Networks of Specialized Care" across the province, including a network for the Eastern region. The Network's mandate is to bring together stakeholders from both sectors to "better coordinate access to specialized services, improve the ways services are delivered and promote professional development through increased sharing of research and training" (Community Networks of Specialized Care,

2007, n.p.). The Network is well positioned to facilitate coordination of individual and systems planning.

To address the challenges to the community integration of individuals with dual diagnosis as a result of the closure of institutional care settings, the Special Project for Systems Integration recommends:

RECOMMENDATION:
CLOSURE OF INSTITUTIONAL CARE SETTINGS

That the Champlain Mental Health Network play a leadership role in facilitating multi-stakeholder, inter-sector consultations to explore advocacy and service planning initiatives with regards to the special needs of individuals awaiting community integration from health and developmental sector institutional settings.

Further, that consultations address the immediate service needs of individuals currently vying for community services, overall systems development issues, and avenues for advocacy regarding ministry mechanisms that impact on integrated service delivery.

SPECIALIZED INPATIENT CARE

Evidence based principles and stakeholder consultations identify an important role for specialized inpatient treatment in the continuum of integrated supports for individuals with dual diagnosis and complex needs. Tertiary hospital inpatient interventions provide specialized care through multi-disciplinary teams that include psychiatry, nursing, psychology, occupational therapy, recreational therapy, social work and behavioural therapy (Lunsky & Puddicombe, 2005). This level of care creates a secure environment to effect comprehensive assessment and active treatment and serves as a center of excellence in dual diagnosis research and education. It has a strong community re-integration focus and works in partnership with community stakeholders (Lunsky & Puddicombe, 2005). Program design and individual treatment delivery are fully informed by specialized knowledge of dual diagnosis. Linkages with community care providers in individual and program planning ensures that patients receive inpatient care when it is required and are able to transition into less intensive levels of care when indicated by their treatment plan.

The ROHCG currently provides specialized dual diagnosis inpatient care through its Brockville based dual diagnosis inpatient unit and two dual diagnosis designated beds in the Evaluation Unit of the Intensive Assessment and Intervention Program in Ottawa. Currently, the Brockville dual diagnosis 20-bed inpatient unit is operating under an interim mandate and is slated for closure pending the community integration of its remaining patients. With 24 patients admitted it is not in a position to also respond to the needs of

individuals in the community. The Evaluation Unit's primary mandate is to provide comprehensive evaluation of patients with unclear diagnosis and complex illnesses. Although it has the capacity to bring specialized services to bear in the assessment and treatment of individuals with dual diagnosis, its program model is not designed specifically for this population. Both the Evaluation Unit and the Brockville program are experiencing difficulties transitioning discharge-ready patients to community settings.

OMHLTC directives to close provincial psychiatric hospitals involve the transfer of responsibility for psychiatric inpatient care to general hospital psychiatric settings and generic tertiary care facilities, such as the Royal Ottawa Mental Health Centre. However, generic tertiary care facilities and general hospital psychiatric inpatient services lack the specialized knowledge of dual diagnosis required to address the needs of these individuals. Generic tertiary and acute care hospital staff are not trained to work with individuals with dual diagnosis. They do not generally engage in the modified diagnostic and multi-disciplinary treatment procedures required by individuals with dual diagnosis. Their staffing levels do not allow for intensive interactions with patients and they lack a strong working knowledge of the developmental service system (Lunksy et al., 2003). These systemic issues can lead to misdiagnosis, inappropriate treatment, and an over-reliance on psychopharmacological interventions (Lunksy et al., 2003). Generic tertiary care units and general hospital psychiatric inpatient services experience difficulties in transitioning patients back to community care as a result of these limitations. This is not an indictment of the generic acute and tertiary inpatient system, but rather recognition that their treatment models do not position them to provide adequate care to the specialized population of individuals with dual diagnosis.

The gulf between the treatment systems of the developmental and health/mental health sectors is demonstrated in the position of the Brockville Mental Health Centre's dual diagnosis inpatient unit within the overall system of supports. Opened in 1978, initial patients were admitted for short-term assessment and stabilization and were then returned to their community care settings. By the mid 1990s, ongoing discharge of individuals with intellectual disabilities and complex needs from OMCSS facilities outstripped community service capacity. Consequently, the demand for inpatient admissions increased, as did the projected the length of stay (CDMHITF, 2002). Repatriation became increasingly difficult as community based agencies did not have the staff nor the programming resources to replicate the secure treatment environment of the inpatient unit. Patients in inpatient beds became less of a priority for housing and support in the developmental sector and many saw their support relationship with community care providers fade over time (Lunsky & Puddicombe, 2005). Ongoing collaboration between the inpatient program and community resources also decreased, and treatment planning at both the individual and program levels became an increasingly isolated process. Opportunities for cross-pollination of knowledge and methods were largely lost

and silos of service development and provision were created between the two sectors.

Recent developments in the inpatient unit's treatment paradigm have seen an attempt to shift from long-term chronic care to tertiary care with an emphasis on community re-integration. This shift is confounded by the program's inpatient treatment model developed within a medical model of care and with a general focus and range of tools that are not fully compatible with those of community care. Inpatient treatment developed within a medical model of care has a stronger focus on assessment and stabilization than on community integration and skill building. The physical environment of the inpatient unit, the nature of its daily operations, and its overall social environment are not compatible with community living environments making the generalization of skills from one environment to the other difficult. Inpatient treatment staff has access to a range of tools and interventions that are not replicated in the community. This is particularly relevant with regards to aggression management practices. When intervening with aggressive patients, inpatient treatment staff can call for immediate back-up from other hospital staff, and they have the option of intervening with locked seclusion, physical, mechanical, and chemical restraints (Lunsky & Puddicombe, 2005). These procedures are largely unavailable in community care settings. The lack of compatibility between the inpatient and community treatment models makes transitioning patients from one setting to the other challenging.

As a result of the disconnected relationship between inpatient and community care programs and the divergence between inpatient and community models of care, inpatients are at risk of becoming institutionalized over the course of their treatment. Behaviours adapted according to inpatient management techniques are unmanageable in community contexts. Relationships with community resources are lost, as are community living skills such as preparing meals, shopping, and interacting in social settings (Lunsky & Puddicombe, 2005). Patients are thereby denied the opportunity to develop, to their fullest potential, the skills they need to integrate into community environments, and they remain in hospital care long after it is merited by the acuity of their symptoms. Without viable placement options, these patients become 'bed blockers', essentially blocking access to inpatient treatment required by community based individuals. The inpatient unit is, therefore, unable to transition individuals into community care when they are discharge-ready, and is unable to respond to the inpatient treatment needs of individuals in the community.

Recent developments in both the inpatient treatment model of the Brockville unit and the developmental sector's system of specialized supports offer promise in terms of the potential to rectify this situation. The Brockville inpatient unit's ongoing transformation to a tertiary model of care for individuals with dual diagnosis better incorporates a biopsychosocial approach to treatment and involves the modification of program elements to offer learning environments that better replicate those of the community. The program has launched a six-

bed transitional unit that is separated from the primary inpatient unit. This transitional unit is designed to provide private rooms in a more relaxed and home-like environment allowing patients greater opportunities for independence and skills development. The unit is consulting with community care providers in the development of the program and is attempting to form partnerships with community programs that will lead to placement opportunities. Consultations have been held with the Eastern Community Network of Specialized Care to coordinate service system developments to best engage the knowledge and resources of each sector.

To best address the specialized inpatient care needs of individuals with dual diagnosis, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
SPECIALIZED INPATIENT CARE

That the ROHCG continue to place a high priority on initiatives to enhance the biopsychosocial and community integration components of inpatient care in their dual diagnosis service. Service developments should proceed with a high degree of consultation and collaboration with community mental health and developmental sector stakeholders to ensure compatibility and integration of services. The Eastern Community Network of Specialized Care should be integrally involved with the ROHCG in the development and implementation of these collaborative initiatives.

RECOMMENDATION #2:
SPECIALIZED INPATIENT CARE

That the Champlain Mental Health Network consult at the leadership level with developmental sector partners, including the Eastern Community Network of Specialized Care, to develop a plan to advocate for the continuance and enhancement of specialized dual diagnosis inpatient care capacity in the health care system.

RECOMMENDATION #3:
SPECIALIZED INPATIENT CARE

That the Champlain Mental Health Network and the ROHCG explore strategies to better position the Brockville Mental Health Centre's dual diagnosis unit in the current system of specialized supports, and that intensive advocacy be engaged for the transformation and repositioning of this service rather than for its closure.

PRIMARY HEALTH CARE SERVICES

Access to specialized primary health care interventions is an integral component of the community integration supports required by individuals with dual diagnosis. Specialized primary health care draws on the resources of multi-disciplines and is informed by an understanding of the unique needs and characteristics of individuals with dual diagnosis. Individuals with intellectual disability and/or dual diagnosis have a high prevalence of comorbid physical and mental health conditions, require more time and attention from their health care providers, and have a greater need for resources in health care than do members of the general population (OMCSS & OMHLTC, 2005). The first point of contact with the primary health care system is normally through family physicians, pediatricians and nurses in private practice clinics, general hospitals, community health centres, and through services facilitated by Community Care Access Centres. Although consultations with hospital and other primary medical care environments and personnel were not part of the activities conducted by the Special Project for Systems Integration, consultations with community based care providers revealed a lack of capacity within primary health services to address the unique needs of the dually diagnosed in a specialized manner. These stakeholders also recognized the implications of this lack of capacity for the community placement of individuals with dual diagnosis.

Individuals with dual diagnosis are vulnerable to the same range of health problems as members of the general population are. Issues associated with their disability leave many at additional risk (Lunsky et al., 2003). A wide range of health problems result from a complex interplay of factors relating to biological risks associated with disability (Lunsky et al., 2003), medication side effects, and lifestyle and environmental factors that are unique to this population. These health problems include epilepsy, respiratory disease, gastro-esophageal reflux disease, chronic constipation, cardiovascular disease, visual and hearing impairments, dental pathology, osteoporosis, thyroid disease, skin problems, nutritional problems, obesity, and many other conditions (OMCSS & OMHLTC, 2005). Symptoms may emerge in ways that are unique from the general population and there are often impairments in the individual's capacity to describe symptoms to care providers and medical personnel. Individuals with dual diagnosis may react with fear and anxiety in unfamiliar clinical environments thereby confounding attempts at diagnosis and treatment. As a result, specialized diagnostic and treatment procedures are required. In their absence, individuals with dual diagnosis are not only at increased risk of experiencing health problems but are also at increased risk of not accessing accurate and timely diagnosis and treatment (Lunsky et al., 2003; OMCSS & OMHLTC, 2005).

Primary health care interventions are key components in the biopsychosocial approach to individual treatment planning for individuals with dual diagnosis. For this population, many of whom lack strong communication skills, physical and emotional distress is often communicated through acting out behaviour.

Problematic behaviours such as aggression and self-injury may be caused by such physical factors as dental pain, social factors relating to interpersonal contacts or environments of care, psychiatric conditions, or a variety of other factors (OMCSS & OMHLTC, 2005). Ruling out medical health conditions is often one of the first steps in isolating the root cause of challenging behaviours and developing effective intervention strategies (Griffiths et al., 1999). Community caregivers interviewed by the Special Project for Systems Integration recounted many cases where medical ailments were masked as mental health challenges characterized by acting out behaviour that was resistant to multiple environmental, behavioural and psychopharmacological interventions. With appropriate medical investigation, the true root of the problem was uncovered, appropriate medical treatment interventions were implemented, and the behaviours were usually extinguished. In the absence of this multi-modal approach to diagnosis and treatment, these individuals would have been at risk of not receiving appropriate treatment of their medical conditions and their symptoms could have worsened. As well, their community placements could have become jeopardized as a result of failed attempts to communicate distress.

A recurring concern raised by community care stakeholders was the capacity of generic primary health services to adequately serve the complex needs of individuals with dual diagnosis. Some individuals with dual diagnosis are able to access appropriate medical care through generic primary health care avenues, but as the complexity of needs increases, particularly in terms of intellectual functioning, the capacity of the generic system to respond decreases. This is a function of the overall lack of specialized training and expertise in intellectual disability and dual diagnosis for primary health care staff, and the lack of modifications to clinical environments and procedures to address the unique characteristics of this population. Education programs for medical and allied health professionals destined for primary health care settings and ongoing training for existing personnel lacks adequate content of intellectual disability and/or dual diagnosis (Lunsky & Puddicombe, 2005; OMCSS & OMHLTC, 2005). This has implications for the capacity of primary health care providers to engage in informed diagnostic and treatment procedures. In the same vein, the physical environments and procedural protocols of primary health care settings are generally not designed to accommodate individuals with dual diagnosis and, therefore, are not responsive to their complex needs.

The result is that dually diagnosed individuals with the most complex needs lack access to specialized and adapted primary health care. Securing access to community based general practitioners and dentists is challenging for the general population, let alone for individuals whose needs are often regarded as exceeding the expertise of these health care professionals. For those willing and able to take on dually diagnosed clients, adaptations are often required. For instance, modifications to methods of history taking and eliciting symptoms, including setting aside more time for interviews with patients, using augmented communication strategies, and integrating the input of a range of caregivers are

often required (Lougheed, 2006). Dental procedures and specialized diagnostic procedures, such as X-Rays, MRIs and CT Scans, can elicit fear and anxiety for many patients and are particularly challenging for individuals who express distress through acting out behaviour. The capacity of the individual with an intellectual disability to understand both the nature of medical procedure and their expected involvement may be impaired. This can result in a traumatic experience for the individual and potentially sub-optimal diagnostic and treatment outcomes. In the general hospital context, emergency room services and inpatient treatment involve personnel, assessment and treatment procedures, and physical environments that are unfamiliar to the individual with dual diagnosis. Even such things as having to wait in a waiting room with other individuals can be problematic for members of this population and a barrier to accessing appropriate service.

Stakeholders consulted by the Special Project for Systems Integration identified the lack of access to adapted and specialized psychotherapy within the primary care system for individuals with intellectual disability and/or dual diagnosis as a key systems concern. Both individual and group therapy have the potential to support people with intellectual disabilities and/or dual diagnosis to address emotional stressors that impact their journey to wellbeing and community integration. These individuals often face a range of emotional challenges, including the impact of current and historical sexual abuse, family and interpersonal relationship issues, stresses related to having a 'disabled' identity, and the need to adapt to community living environments. Although historically the efficacy of psychotherapy for individuals with dual diagnosis has been questioned, the past 20 years have seen significant developments in research that support adapted models of psychotherapy (Lynch, 2004). Adaptations include modifications to address cognitive, developmental, and speech/language deficits such as simplifying language, presenting information at a slower rate, and using concrete language, non-verbal communication, visual materials, and role-playing methods (Lynch, 2004). Adapted psychotherapy is not accessible within the current system of supports. This negatively impacts the ability of individuals with dual diagnosis to fully realize their potential for emotional wellbeing.

"Some individuals with dual diagnosis are able to access appropriate medical care through generic primary health care avenues, but as the complexity of needs increases, particularly in terms of developmental functioning, the capacity of the generic system to respond decreases."

In the course of its consultations, the Special Project for Systems Integration identified initiatives that move toward addressing some of these primary health care service delivery issues. In some cases, developmental sector residential care providers have established ongoing working relationships with local dentists and general practitioners as well as service protocols to address concerns and needs

for the practitioner, client, and care provider. Within these service protocols, administrative and clinical processes are modified to facilitate appropriate, informed, and responsive service delivery. CMHA Ottawa's dual diagnosis programming includes a dual diagnosis community clinic that uses a shared care model to provide consultation to family physicians and other health personnel as part of its range of services (this program is explored in more detail below). The Dual Diagnosis Action Group, a committee of front line developmental and mental health staff spearheaded by CMHA Ottawa's Dual Diagnosis Program, is exploring opportunities to recruit general practitioners willing to serve individuals with dual diagnosis and to facilitate access to necessary training. The psychiatric residency curriculum at the University of Toronto includes systematic teaching in intellectual disability and Queen's University has established an intellectual disability section within its school of psychiatry. In 1995, health practitioners, administrators and academics from a range of disciplines took part in a colloquium sponsored by Toronto's Surrey Place Centre Foundation and Ontario's Ministries of Community and Social Services and Health and Long Term Care. The colloquium developed comprehensive guidelines and recommendations with respect to the provision of primary health care to people with intellectual disabilities in Ontario, and to the provision of education and support to health care providers.

These initiatives, and many others not listed, recognize the need to enhance primary health care for individuals with intellectual disabilities and/or dual diagnosis, and to provide examples of concrete measures to achieve these enhancements. Accordingly, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
PRIMARY HEALTH CARE SERVICES

That the Champlain Mental Health Network initiate consultations between health and developmental sector stakeholders to identify and engage concrete initiatives to enhance training in intellectual disabilities and dual diagnosis for existing primary health care staff and advocate for the inclusion of relevant content in the education programs for medical and allied health professions.

RECOMMENDATION #2:
PRIMARY HEALTH CARE SERVICES

That concrete initiatives be taken to facilitate the enhancement and modification of primary health care clinical processes and protocols to better address the needs of individuals with intellectual disabilities and/or dual diagnosis.

EMERGENCY/CRISIS SERVICES

The Special Project for Systems Integration consultations identified the lack of access to specialized dual diagnosis psychiatric emergency response interventions as an area of significant concern to community caregivers and other systems stakeholders. Diagnosis and treatment of individuals with dual diagnosis requires integrated tertiary services that are both community and hospital based, that are informed by knowledge and expertise in dual diagnosis, and that have the capacity to provide biopsychosocial assessment and treatment. There is a need for both crisis prevention and intervention mechanisms including mobile support, short-term crisis and respite bed capacity, and enhanced dual diagnosis capacity in general hospital emergency rooms. Early crisis response and the capacity to intervene as early as possible with a broad base of services can avoid unnecessary admissions to inpatient psychiatric settings for individuals with dual diagnosis.

Hospital-Based Emergency Services

Hospital based psychiatric emergency services are provided through general hospital emergency departments. Emergency services assess the medical stability of individuals, provide psychiatric assessments, and liaise with inpatient psychiatric services and appropriate community resources to ensure appropriate levels of care are initiated. The lack of specialized knowledge of dual diagnosis already identified in primary health care services also applies to psychiatric emergency response services. Emergency services generally lack specialized procedures and mechanisms to accommodate the unique needs of the dually diagnosed and emergency service personnel lack the requisite knowledge of dual diagnosis to provide specialized interventions (Lunsky & Puddicombe, 2005). Emergency waiting rooms can be anxiety provoking for individuals in crisis, and they are particularly problematic environments for individuals who are prone to behavioural expressions of distress. Diagnosis requires adapted assessment procedures in terms of communication techniques, nature of information sought, and caregivers consulted. Assessing a client with a dual diagnosis may take up to four times longer than the time required to assess someone without this condition (Bradley, 2002). The level of response available through generic psychiatric emergency department services does not adequately meet the specialized needs of individuals with dual diagnosis. This gap has significant implications for the community integration of individuals with complex needs.

Some community stakeholders have been successful in developing protocols with emergency services that facilitate a limited range of adapted processes for particular clients, many of whom have histories of multiple emergency room visits. Stakeholders reported that these protocols were able to mitigate, to some extent, the limitations inherent in the emergency response system. These individual initiatives do not, however, represent a systems-wide enhancement of service, nor are they able to address all areas of concern with regards to hospital

based emergency services. Inter-sector consultations and collaborative initiatives in systems enhancement and integration are required to appropriately address this issue on a systemic basis. Service enhancements must address the treatment environment of the emergency unit and be integrated with community-based crisis prevention and intervention supports. To this end, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
EMERGENCY/CRISIS SERVICES

That the Champlain Mental Health Network initiates inter-sector consultations to facilitate adaptations to hospital-based psychiatric emergency services to meet the special needs of individuals with intellectual disabilities and/or dual diagnosis.

Further, that these consultations explore mechanisms to enhance access to comprehensive primary medical and psychiatric services in hospitals above and beyond emergency related treatment.

Community Based Crisis Services

The health sector's mental health crisis response system includes community based services that are designed to be accessed from and intervene within the individual's community setting. These services are intended to provide early assessment and intervention to prevent crises from escalating to the point where emergency unit interventions are necessary. They also facilitate effective emergency response when it is required. They have the potential to provide consultation and education to individuals and care providers to enhance their capacity to prevent and address mental health challenges. In the Ottawa-Carleton context, these services are accessed through programs such as the Champlain Mental Health Crisis Line and the Mental Health Mobile Crisis Team.

The Champlain Mental Health Crisis Line (Crisis Line) provides a first point of public access to the mental health crisis response system. It provides toll free, 24 hour,7 days a week access to bilingual telephone support from trained volunteers who are supported by professional staff. The Crisis Line provides support in times of crisis, suicide intervention, screening and assessment, referrals, and transfer to local crisis teams or emergency services when required. Crisis Line support can be accessed by individuals, family members, and caregivers. The Crisis Line works in conjunction with the Mental Health Mobile Crisis Team. The Mobile Crisis Team provides direct intervention for individuals experiencing a mental health crisis in the community. They work in collaboration with hospital emergency rooms, psychiatrists, and other mental health and first line services. The Mobile Crisis Team intervenes with the

individual in their community setting and attempts to engage the least intrusive approach to resolving the crisis. The Mobile Crisis Team is comprised of crisis counselors, nurses, and social workers and has access to psychiatric consultations. Its services include assessment, crisis intervention, consultation, and links to community supports. The Mobile Crisis Team has also developed, in collaboration with community residential service providers, the capacity to provide access to short term crisis beds. Placement is on a short-term basis (targeted five days), and interventions provided during the stay include the facilitation of follow-up supports.

Interventions accessed through the Mental Health Crisis Line and the Mental Health Mobile Crisis Team contain many of the components of community based crisis support required for the successful community integration of individuals with complex mental health needs. The volunteers and/or professional staff have experience in and skills for supporting individuals and caregivers through crisis situations. They have the capacity to mobilize multi-disciplinary support in the individual's community setting and are able to facilitate access to community based crisis beds. What Crisis Line, Mobile Crisis Team and community residential crisis bed personnel lack is specific knowledge and expertise in dual diagnosis. While their service criteria do not preclude individuals with dual diagnosis, they have limited capacity to effectively serve those with the most complex needs. While there remains a role for this model of service in the overall framework of crisis supports for individuals with dual diagnosis, systems enhancements are required to support those individuals with the most complex intellectual and mental health needs.

The Eastern Region Community Network of Specialized Care has recently announced OMCSS approval for the development of a Crisis Prevention and Intervention Program (CPIP). The CPIP will provide crisis prevention and intervention services that include mobile response capacity, on-site clinical supports and training, and respite and emergency housing in specialized and high support residential services. The CPIP will collaborate with emergency first response systems for immediate crisis response as well as with hospitals for the provision of short to medium term treatment beds. The CPIP team will be comprised of multi-disciplinary personnel with knowledge and experience of dual diagnosis. Their mechanisms and processes will be designed to meet the unique needs of this population. The Eastern Region Community Networks of Specialized Care have a mandate to facilitate consultation, collaboration and integration of services from various sectors. Thus, the development of the CPIP provides a forum for crisis service system planning across sectors. This offers an opportunity to engage in multi-stakeholder consultations in the development of a new service, to explore dual diagnosis service enhancements for existing programs, and to establish access protocols that engage specialized services when complexity of needs surpass the capacity of generic supports. The Special Project on Systems integration recommends:

RECOMMENDATION #2:
EMERGENCY/CRISIS SERVICES

That the Champlain Mental Health Network consult and collaborate with the Eastern Region Community Network of Specialized Care in the ongoing development of the Network's Crisis Prevention and Intervention Program.

COMMUNITY BASED TERTIARY CARE

Tertiary care involves specialized interventions delivered by highly trained staff across a range of institutional/inpatient and community based settings (Wasylenki, 2000). Tertiary community based services are key components in an effective community integration system for individuals with dual diagnosis. The integration of dual diagnosis-specific tertiary community supports into the treatment dynamic enhances the capacity of services across sectors and settings to meet the needs of this population. Tertiary services that have dual diagnosis expertise provide direct service to individuals, families and community caregivers that might not be accessible otherwise. They also have the ability to provide consultation and education across settings to enhance the capacity of existing services to address specialized needs. When services are integrated across sectors and settings, with strong collaborative and consultative links, the capacity of each component to contribute to the overall support plan is maximized. Proper coordination and integration ensures that programs are not called upon to provide services that are beyond their intended scope.

Individual Planning and Service Brokerage

The initial development and implementation of community integration plans that involve the input of multiple stakeholders across sectors and settings require the coordination and brokerage of a number of distinct services. This is the mandate of individual planners, service brokers, and case managers. In the Ottawa context, developmental services are accessed centrally through Service Coordination. Individuals who are assessed to have the most complex needs are referred to Citizen Advocacy and/or the CMHA Dual Diagnosis Brokerage program for individual service planning. These programs will not be discussed in detail here. In general terms, however, they have established links with developmental and health/mental health service providers, and they lead the development of networks of support that "wrap-around" the individual to address their needs from a biopsychosocial perspective. These programs work in collaboration with inpatient social workers, community based case management staff, and other stakeholders to assess strengths and needs, and to identify treatment domains to be addressed in establishing and/or maintaining community placement. Planning initiatives involve the engagement of varying

programs in integrated interventions that capitalize on service capacity and facilitate system building. There is a strong advocacy and systems-building component to these activities. While this quality, integrated planning maximizes the capacity of existing resources to address the needs of individuals with complex needs, it cannot overcome the significant gaps in resource availability in systems support or mitigate the divergent access criteria and funding mechanisms discussed previously.

Individual planning and service brokerage interventions are focused on linking resources to establish long term treatment plans. Many individuals with dual diagnosis require long term intensive case management support to follow through with, and modify, treatment plans through the course of their community tenure.

Specialized Community Consultation

Programs that provide biopsychosocial assessment, diagnosis, and treatment plan development consultations are integral components of a community based tertiary care system for individuals with dual diagnosis. These programs inject expertise into the network of available supports and offer direct service, education and consultation to support partners. The integration of this consultative capacity has the potential to bridge the gap in expertise in such critical treatment domains as psychiatry, psychology, general practitioner, nursing, and allied health. In the Ottawa context, community based specialized consultation is provided through such programs as the Royal Ottawa Hospital's Dual Diagnosis Consultation Outreach Team (DDCOT), the Ottawa Children's Treatment Centre's Behavioural Services for Adults (OCTC Behavioural Services), and the Canadian Mental Health Association's Dual Diagnosis Community Clinic (DD Clinic). These programs have developed protocols of individual and integrated services that demonstrate the efficacy of specialized, multi-disciplinary consultation.

The DDCOT provides short-term assessment, diagnosis, consultation, education, and coordinated treatment planning through a team of professionals with dual diagnosis expertise. Team disciplines include psychiatric nursing, social work, speech and language pathology, occupational therapy, psychology, and psychiatry. This provides the capacity to engage coordinated biopsychosocial diagnostic and treatment formulations. The team has mobile capacity and the ability to assess and consult within the individual's living environment. Assessment and treatment plan development is facilitated in collaboration with the individual's systems of support including family, community caregivers, and other professional services. The DDCOT does not provide crisis response or ongoing case management. Some follow up support to treatment implementation is provided, but generally service is terminated when treatment plans are established and engaged. The DDCOT does not provide direct treatment to individual clients but does provide consultation with support systems in the development and implementation of treatment plans.

The DD Clinic was initiated to address the need for specialized dual diagnosis psychiatric diagnosis and treatment. The program works in partnership with the DDCOT, OCTC Behavioural Services, community health centres, general practitioners, developmental and mental health support services, families and caregivers, and other identified stakeholders. The DD Clinic provides initial biopsychosocial assessments, meaningful diagnosis, and referrals to medical specialists when appropriate. The program works in a "shared care" relationship with community health centres and general practitioners providing consultation in the diagnosis and treatment process. A multi-stakeholder team approach is facilitated, and the capacity of community stakeholders to provide service is enhanced by the injection of specialized psychiatric assessment and treatment. Outcomes of this service include the provision of informed diagnoses and treatment recommendations that facilitate the prevention of family and community placement breakdown and reductions in unnecessary emergency room visits and hospitalization.

OCTC Behavioural Services provides consultation to individuals and stakeholders in the city of Ottawa regarding adults with intellectual disabilities requiring behavioural management. The program has a staff of psychologists and behavioural consultants who facilitate biopsychosocial assessments of behavioural concerns and assist caregivers in developing behavioural treatment plans. Assessments consider account factors that relate to the individual's skills, the impact of environment, the function of behaviours, and the influence of medical, psychiatric and social/cultural dynamics. Assessments and treatment plans are developed in consultation with other specialized services, family, and caregivers. Training in positive behavioural support is provided to caregivers and residential treatment staff to facilitate the implementation of treatment plans. Program staff have regular meetings with stakeholders to review the progress of behavioural treatment plans.

These community consultation services provide crucial dual diagnosis clinical supports that are unique to their individual programs and that emerge from the integration and collaboration of multiple stakeholders. They facilitate an infusion of dual diagnosis expertise through direct interventions, the development of networks of support, and the provision of education and consultation. Their specialized expertise represents a crucial component in the provision of tertiary community care to individuals with dual diagnosis both in terms of the direct service they provide, and of their ability to enhance the capacity of other non-specialized services to play an active role in supporting community integration. However, stakeholders question the capacity of these programs to meet the growing need for this level of specialized service as de-institutionalization in both the health and developmental sectors proceeds. As systems development is pursued by both sectors, enhancing the resources and capacity of these programs should be given high priority. These programs also have the potential to provide valuable input into the support system development process. Their input is particularly relevant as the Eastern Region Community Network of Specialized Care proceeds with initiatives to enhance

access to, and integration of, specialized services across sectors. Consultations between the Network and the programs described above is imperative in assuring collaboration and integration of service protocols, establishing clear access criteria, and avoiding duplication of services. Thus, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
COMMUNITY BASED TERTIARY CARE

That the Champlain Mental Health Network initiate consultations between health/mental health and developmental sector stakeholders, to advocate for the enhancement of specialized dual diagnosis community consultation services, and that these consultations include the input of the DDCOT, CMHA DD Clinic, OCTC Behavioural Services, Community Networks of Specialized Care, and other stakeholders with which these services have formed linkages.

Outreach and Intensive Community Support

The consultative programs described above provide crucial input into community based assessment, diagnosis, and treatment planning. However, their ability to provide ongoing support in treatment plan implementation is limited by the nature of their service models. For many individuals with dual diagnosis, the ability to access long-term, intensive support in their community is essential to maintaining community integration. This level of support provides a link between clinical assessment and treatment plan development and the ongoing facilitation of treatment interventions in placement settings. Programs that provide intensive, integrated and rehabilitative community treatment with the capacity to intervene with 24-hour, 7 days a week clinical and support services are key components in the provision of this type of community based tertiary care (Lunsky & Puddicombe, 2005; Wasylenki, 2000). Intensive case management (ICM) and assertive community treatment (ACT) teams typically provide this type of support. Other models of less intensive outreach and case management service have a role in the continuum of supports as well. As with consultative programs, these community based supports provide direct service to individuals and enhance the capacity of stakeholders who work with them. Although not specifically crisis response systems, these programs often have the capacity to support in-crisis situations and have established relationships of trust with the individual and their caregivers that provide a strong foundation for intervention.

There is limited access, in the current system of supports, to long term, intensive case management services that have a specialty in dual diagnosis and/or intellectual disability. Individuals receiving community integration support from developmental services transfer payment agencies, and particularly those receiving residential support, have access to case management interventions

through those agencies. This is typically performed by front line staff who provide on-site daily living support and ensure that individual support plans are developed and implemented. The lack of integration in the planning and provision of treatment interventions between the health and developmental sectors results in a limited range of multi-stakeholder mechanisms to support the case management work of these staff.

Individuals with dual diagnosis access generic intensive case management through the Mental Health Community Support Services (MHCSS) of CMHA Ottawa. The Case Management Service of MHCSS provides intensive, client-directed support to individuals with severe and persistent mental illness who lack adequate services and require significant ongoing support to access needed interventions. The program is a partnership of health/mental health organizations and is coordinated by CMHA with case managers located at partner agencies. Individuals with dual diagnosis are able to access this program and case managers are able to facilitate linkages with dual diagnosis specialized services, but the program is not designed to meet the specific needs of individuals with dual diagnosis. Due to the complexity of needs and intensity of services required, dual diagnosis clients often require more attention from case managers than do individuals without dual diagnosis. As is the case with generic programs, including those designed to provide intensive support, the capacity to adequately address the needs of the dually diagnosed decreases as the complexity of intellectual needs increases.

"What is required is a system with robust, generic and specialized supports that are integrated and collaborative, that maximize the potential of generic services to support this population, that clearly delineate target populations for whom specialized services are required, and that engage responsive assessments and referrals for appropriate levels of service."

The Psychiatric Outreach Team of the ROHCG represents a model of short-term outreach support designed to provide community based service to individuals with severe and persistent mental illness. The program targets individuals who are not likely to use traditional hospital-based services and who are at risk of homelessness and hospitalization as a result of challenges adapting to community living. The Psychiatric Outreach Team draws on multiple disciplines including addiction support, occupational therapy, psychiatry, psychiatric nursing, psychology, recreational therapy, and social work. The program works with both the individual and the community agencies that serve them to provide preliminary psychiatric assessments, support and education, and to promote linkages to appropriate community based services. Although this program is accessible to individuals with dual diagnosis, it has limited capacity to address the unique needs of this population. Furthermore, as a short-term service (generally of six

month's maximum duration) it does not provide the ongoing, long-term support that this population often requires.

Longer term outreach support with a specialty in intellectual disabilities is available through the Y's Owl Maclure Cooperative Centre's Outreach Program. This program provides outreach support to individuals with intellectual disabilities living in community settings. The outreach philosophy focuses on therapeutic relationship development between the individual and outreach workers. Interventions take place in the individual's community living environments. Outreach workers are able to support the individual in all aspects of community living skills development. To access the service, individuals must have a basic ability to use public transportation independently, the capacity to engage safely and appropriately in community based activities, and be willing and able to actively engage in an ongoing therapeutic relationship with outreach workers. Outreach workers have the capacity to support individuals with complex needs through challenging situations, but there is limited capacity within this model to meet the cognitive, behavioural, and psychiatric needs of individuals with dual diagnosis. Although the program's access criteria do not specifically preclude service to the dually diagnosed, overall intensity of needs limits the efficacy of this model of outreach support for this population. Individuals with the most complex needs require intensive community support and a capacity of services along a wider continuum in terms of cognitive, behavioural, and psychiatric needs.

Assertive community treatment (ACT) is a mobile, community based model of tertiary care that supports the community integration of hard to serve individuals with severe and persistent mental illness. Unlike the Psychiatric Outreach Team model, ACT has the potential to provide long-term services. Like the Psychiatric Outreach Team, ACT typically serves individuals who have histories of heavy use of mental health services, including inpatient care, and who do not typically engage well with traditional models of mental health support. This service uses a team approach, whereby multiple disciplines share responsibility for treatment planning and facilitation (Stein & Santos, 1998; Wasylenki, 2000). The team is comprised of a range of disciplines including psychiatry, nursing, social work, occupational therapy, recreational therapy, addictions support, community mental health, and peer support. ACT provides direct service to individuals in their community environment, provides support and consultation to existing caregivers, and brokers access to other services. It is not a case management program. ACT has the capacity to provide 24 hour, 7 days a week service and although it is not specifically a crisis-response system, it is able to intervene with supports in times of crisis. This model is particularly effective at facilitating diagnosis and treatment formulations and assisting individuals and their caregivers with maintaining medication compliance.

In the Ottawa context, ACT services are provided through generic ACT teams. Individuals with dual diagnosis who meet the criteria for service are able to access ACT support. ACT services are key components in supporting the

community integration of a range of dually diagnosed individuals. This is particularly the case for those who have the capacity to live in less specialized and supervised residential settings such as independent and semi-independent living settings and domiciliary hostel care. Stakeholders are concerned, however, whether generic ACT services have the capacity to adequately serve individuals with more extreme intellectual impairments for whom dual diagnosis specialized ACT services are required (Lunsky & Puddicombe, 2005). There is a dual diagnosis specialized ACT program at the Brockville Mental Health Centre (Assertive Community Treatment Team for Persons Dually Diagnosed), however its geographic service area does not include Ottawa. It is the only program of its kind in the province. Access criteria for generic ACT services are problematic for individuals with dual diagnosis in community placements as they often lack the extensive days of hospitalization required. As well, ACT criteria requires a clear Axis I psychiatric diagnosis and many individuals who have been designated as dually diagnosed based on intellectual disability and extreme behavioural challenges may not yet have a solid Axis I diagnosis.

There is a point on the continuum of intellectual disability and complexity of needs at which generic services become less effective in supporting the individual with dual diagnosis. This is the point at which specialized services are needed. What is required is a system with robust generic and specialized supports that are integrated and collaborative, that maximize the potential of generic services to support this special population, that clearly delineate target populations for whom specialized services are required, and that engage responsive assessments and referrals for appropriate levels of service. The current service system of intensive community support lacks specialized knowledge of dual diagnosis. The developing Community Networks of Specialized Care has the potential to play a formative role in this area. The CPIP program has elements of intensive community support and intensive case management in its intended model of service. Strong consultation and collaboration with existing intensive community support programs is recommended if an integrated system of specialized and generic services is to be developed.

RECOMMENDATION #2:
COMMUNITY BASED TERTIARY CARE

That the Champlain Mental Health Network engage in consultations with the Eastern Region Community Network of Specialized Care to ensure that health sector intensive community support programs play an active, consultative, and collaborative role in the ongoing development of specialized services being undertaken by the Network, and that these consultations explore mechanisms to ensure inter-sector integration of specialized, intensive community support services.

HOUSING/RESIDENTIAL SUPPORTS

Stakeholders reported limited access to appropriate and sustainable community based residential services as the most significant systems issue impacting the capacity of current supports to facilitate the community integration of individuals with dual diagnosis. Appropriate and sustainable housing provides access to a range of residential options that meet the varying needs of individuals over time. Within an appropriately resourced system, residential options exist on a continuum from least to most intensively supportive environments and are linked and integrated at all points to intensive community supports. Individuals thereby have access to flexible housing and supports that meet their individual needs and that are adaptable as those needs change over time. The Special Project for Systems Integration found that the services most lacking on the residential support continuum were those that address the needs of individuals with the most complex intellectual, mental health, and physical care needs.

Many individuals with dual diagnosis can manage in community settings with limited support. For these individuals, community integration can be accommodated in more independent living settings, particularly when combined with such features as municipal social housing and mental health based rental supplements, semi-independent housing that provides occasional staff support, rehabilitative housing that leads to more independent settings, or models such as domiciliary care that provide limited staffing support. However, these levels of residential placement are not adequate to meet the needs of those dually diagnosed individuals with the most complex needs. The overall problem severity as defined by self-care and daily living needs, risks of danger to self and others, and vulnerability to harm from others far outstrips the capacity of less intensive models of residential care. While access to integrated, intensive community services is a requirement at all points on the residential support continuum for individuals with dual diagnosis, it cannot compensate for overall deficiencies in residential care models.

Within the health care sector, Homes for Special Care settings offer potential supportive living environments for individuals with mental health needs. Homes for Special Care partners with existing community residential care providers to identify and license appropriate care settings. They also provide financial subsidies to support personal care and programming. Homes for Special Care placements are often supported by intensive community services such as assertive community treatment and intensive case management. In the Ottawa context, Homes for Special Care placements are largely accessed through residential services provided by the Ottawa Housing Supported Independent Living domiciliary hostel program. The domiciliary hostel system has limited capacity to provide residential treatment in secure and highly supervised environments that are often required by individuals with dual diagnosis. Domiciliary hostel staff has limited expertise and capacity to engage biopsychosocial programming with regards to individuals' communication,

community living skill building, psychiatric, behavioural and interpersonal needs. While Homes for Special Care has been able to secure placements for individuals with dual diagnosis, these are primarily individuals with higher functioning levels. Homes for Special Care has had difficulty identifying single room accommodations in smaller care settings with specialized care capacity. The ability of this model of care to meet the needs of the dually diagnosed decreases as the complexity of needs increased. Currently, Homes for Special Care lack the necessary specialized care capacity to meet the needs of individuals with dual diagnosis.

Residential treatment facilities, the most intensive level of community residential support identified by evidence based research and stakeholder consultations, is not available in the services provided by either the developmental or health sector. This residential model emerges as an alternative to tertiary inpatient care for individuals who need high levels of support in secure, supervised settings, but not the clinical expertise of tertiary inpatient care (Lunsky & Puddicombe, 2005). A residential treatment facility has the capacity to provide 24 hour, 7 days a week interdisciplinary clinical and individual services that are informed by dual diagnosis expertise, have a strong rehabilitative focus, address behavioural challenges, support all aspects of daily living, and are linked to other intensive community supports (Lunsky et al., 2003). This residential model is placed on the continuum between tertiary inpatient care and more independent community residential services. There is the potential for this model to provide long term, and perhaps permanent care, to individuals who require it and to facilitate transition to less intensive settings, when appropriate. This level of care could be provided by existing models of service, such as nursing and long-term care homes and group home settings, if they had the enhanced capacity to address the complex needs of dually diagnosed individuals within secure environments (Lunsky & Puddicombe, 2005). In the Ottawa context, this level of enhanced capacity is currently not available in nursing and long-term care or group home settings. To enhance the housing/residential supports available to individuals with dual diagnosis, the Special Project for Systems Integration recommends:

RECOMMENDATION #1:
HOUSING/RESIDENTIAL SUPPORTS

That the Champlain Mental Health Network place a high priority on advocating for the development of a residential treatment facility within the current system of specialized community supports available to individuals with dual diagnosis.

The Ministry of Community and Social Services transformation agenda for developmental services identifies health sector long-term care facilities as potential service providers for some individuals entering the community from institutional care settings and particularly for those whose health care needs are greater than what can be supported through community based health care. This includes individuals who require the availability of 24 hour nursing care and supervision within a secure setting. Consultations with inpatient social work staff, service brokers, community support programs, and Community Care Access Centre personnel revealed that while this option may be appropriate for some individuals with dual diagnosis, it has limited application for those with more complex mental health and/or behavioural concerns.

As with other generic professional services, long term care staff lack training and expertise in intellectual disabilities and/or dual diagnosis. Long term care facilities have limited capacity to address acting out behaviour and this leaves other residents of the home at risk to serious injury in cases of co-resident aggression. Consultations revealed cases where non-aggressive behaviours such as excessive vocalizations precluded access to long-term care facilities. Stakeholders also expressed concerns as to whether current long-term care environments are the most appropriate settings for younger individuals who, in addition to their need for intensive physical and/or nursing care, have divergent programming and activity needs to other residents. The capacity of long-term care facilities to address the complex needs of the dually diagnosed population can be enhanced by linkages to specialized community supports, and there are examples of shared care partnerships between long-term care programs and developmental service transfer payment agencies that have facilitated long-term care for some individuals who might otherwise not have been provided service. There remains, however, a considerable population of individuals with significant medical and daily care needs whose behavioural profile precludes access to long-term care facilities. This holds true for long-term care settings that have a greater mental health focus, such as the Royal Ottawa Place of the Royal Ottawa Health Care Group. Accordingly, the Special Project for Systems Integration recommends:

RECOMMENDATION #2:
HOUSING/RESIDENTIAL SUPPORTS

That the Champlain Mental Health Network initiate cross-sector consultations to explore the capacity of long-term care facilities to meet the needs of individuals with dual diagnosis and that these consultation explore the efficacy of this model with regards to its application across the spectrum of complex needs, with a view to identifying mechanisms to enhance specialized services for those situations where long-term care is deemed appropriate.

In the Ontario context, the residential model that has played the most significant role in supporting the community integration of individuals with intellectual disabilities, including those with dual diagnosis, is the community living residential supports provided by the OMCSS funded transfer payment agencies. These programs provide a range of community based models of accommodation with varying levels of support, including group living, supported independent living, and Familyhome care (similar to foster care). They have been at the leading edge of advocacy for systems improvements and have borne the brunt of pressures to support complex needs individuals with insufficient resources. Their capacity to provide specialized residential support to individuals with intellectual disabilities and intensive needs and/or dual diagnosis is negatively impacted by limited internal resources and limited access to specialized supports from tertiary community and inpatient services. The Special Project for Systems Integration conducted extensive consultations with this stakeholder group.

The evolution of the transfer payment agency residential model has been informed by the community integration agenda of the OMCSS. Yet, OMCSS has had a limited mandate for the development of specialized resources to address the health and mental health needs of individuals with intellectual disabilities and/or dual diagnosis. The result has been that transfer payment agencies have been granted limited internal resources to serve individuals with complex physical, behavioural, and psychiatric challenges. This is further compounded by the overall lack of integrated services with intellectual disability expertise in the health and mental health sector. Community caregivers who struggle to meet the intensive needs of the dually diagnosed in their residential settings face, on a daily basis, a lack of availability of specialized inpatient care, primary health care, emergency and crisis response, and intensive community support for individuals with dual diagnosis.

Consultations with transfer payment agencies identified significant concerns with regards to their ability, from a financial perspective, to recruit and retain staff with education and experience in dealing with complex behavioural, physical, and psychiatric needs. Existing residential staff has limited expertise in mental illness, dual diagnosis, and biopsychosocial treatment approaches. Furthermore, these agencies indicate that they do not have the resources to facilitate ongoing training for existing staff to enhance this capacity. Their resources are limited to the extent that they have difficulty not only in providing independent, in-house training but are often limited in their ability to facilitate staff attending external training provided by community partners. Even training that is offered free of charge presents significant financial challenges. Notwithstanding these constraints, these agencies have been diligent and creative in pursuing all possible avenues for training within limited resources. These stakeholders identify the need for enhanced funding to facilitate staff training and access to a wide range of training opportunities including workshop-based teaching initiatives and training provided by intensive community support services to support clients in group care environments.

There are a number of forums, within the current system of services, in which opportunities to enhance training resources can be pursued. The Dual Diagnosis Action Group, a working group of front line staff from developmental and health/mental health agencies, has developed a 'lunch and learn' training series targeting community and residential support staff. This training initiative has been developed within existing resources. There are also opportunities, through multi-stakeholder collaboration, to enhance the provision of training and education through intensive community support and dual diagnosis consultation programs. Enhanced working relationships between specialized inpatient services and community support programs have the potential to infuse training and education in treatment planning. The Community Networks of Specialized Care have identified the need for enhanced training as a key priority. As their initiative unfolds, there is potential for inter-sector collaboration to bridge this important gap in resources.

To enable the training of individuals in the housing/residential sector supporting the needs of the dually diagnosed, the Special Project for Systems Integration recommends:

RECOMMENDATION #3:
HOUSING/RESIDENTIAL SUPPORTS

That the Champlain Mental Health Network collaborate with developmental sector stakeholders, including transfer payment agencies and the Eastern Region Community Network of Specialized Care, to advocate, at the Ministry level, for enhanced human resources funding and training resources for community residential care programs.

RECOMMENDATION #4:
HOUSING/RESIDENTIAL SUPPORTS

That the Champlain Mental Health Network collaborate with developmental sector stakeholders, including transfer payment agencies and the Eastern Region Community Network of Specialized Care, to identify strategies to maximize access to specialized dual diagnosis training, within existing resources, for community residential programs.

Addressing challenging acting-out behaviour is a particular concern for community residential care providers. Community care settings lack the procedures and tools used in specialized inpatient care units. This results in significant safety concerns for staff and other residents. For many individuals with challenging behaviour, the intensity of behavioural presentations will vary over time. Consultations with community residential program stakeholders indicated that they have limited capacity to provide flexible levels of staffing to

accommodate these fluctuations. As well, community based group homes have insufficient single-room accommodations that are often required for individuals whose behaviours emerge in interpersonal and social settings. Group homes are not typically funded to provide daytime support for residents, and securing placements often depends on the availability of existing day programming. Although day programming is available in various in-house and center-based programs, the capacity of these services to address challenging behaviours is limited. When challenges arise in day program settings, residential providers are called upon to intervene, often returning the individual to their group home. Existing funding does not accommodate this level of staffing. As well, this dynamic creates safety concerns related to transporting individuals in crisis. In terms of staffing capacity, staffing expertise, and overall model of service, community residential programs do not have sufficient mechanisms to accommodate the behavioural needs of individuals with dual diagnosis and complex behaviours. In many cases, they are overwhelmed by the needs of individuals currently in their care and they have limited capacity to take on new residents with similar, or more extensive, levels of need.

A significant challenge faced by transfer payment agencies in playing an active role in the community integration of individuals from specialized health sector inpatient settings stems from the sheer lack of available placement openings within their programs. Notwithstanding the lack of specialized staffing and mechanisms discussed above, these programs are faced with dramatic increases in referrals for service presented by the simultaneous de-institutionalization initiatives of the health and developmental sector. Individuals leaving developmental sector institutions generally have significantly more financial resources designated to their care, and service system enhancements at the community residential level are naturally tailored to this population. In this regard, individuals from health sector settings bear the impact from the lack of coordination of these initiatives.

CONCLUSION

The Special Project for Systems Integration conducted extensive research and consultations with service system stakeholders in its investigation of the capacity of Ottawa-based support systems to facilitate the community integration of individuals with dual diagnosis. In general terms, these consultations revealed a dual-sector system of support that lacks adequate levels of integration and collaboration. Where both the developmental and health sectors offer a base of specialized services as determined by their primary mandates, limited collaboration and integration between the sectors confounds the potential for each sector to be informed by the other's expertise with regards to the intellectual and mental health aspects of dual diagnosis. Inadequacy of resources further limits the capacity of either sector to initiate dual diagnosis specialized interventions. The result is a failure, within sectors and on a systems-wide basis, to provide individualized and specialized service to this complex-needs population. This lack of individualized and specialized service impacts all domains of the individual's journey of recovery and community integration.

"Isolated cases of collaborative, specialized, and integrated service delivery do exist, but they emerge more from the initiatives of individual programs than from systematic features. These initiatives, however, demonstrate the potential for integrated and specialized service delivery and provide a base of advocacy for a systems wide transformation of services."

Although there is a lack of integration between developmental and health sector supports for the dually diagnosed, the Special Project for Systems Integration found widespread acknowledgement, amongst service programs from both sectors, of the need to address this issue. It also found a willingness on the part of service providers to play an integral role in systems transformation. Service providers in both the health and developmental sectors have long struggled to address the needs of individuals with dual diagnosis within their base of interventions, but these efforts have had limited success in supporting the community integration of those individuals with dual diagnosis who have the most complex needs. Isolated cases of collaborative, specialized, and integrated service delivery do exist, but they emerge more from the initiatives of individual programs than from systematic features. These initiatives, however, demonstrate the potential for integrated and specialized service delivery, and provide a base of advocacy for a systems-wide transformation of services.

The Special Project for Systems Integration has identified systems issues and recommendations for operational improvements. The evidence based principles on which these findings are based, and the recommendations for change that emerge from them, are largely reflected in existing international, national and provincial policy and evidence-based practice documents. To a large extent, this research confirms a need for change previously recognized and a direction for change already largely defined. What remains to be seen is whether the systems of health and developmental services in Ottawa are able to translate principles and recommendations into concrete action and systemic change.

APPENDIX A

DATA GATHERING ACTIVITIES

IDENTIFICATION OF TARGET POPULATIONS

The Special Project for Systems Integration initiated a range of activities to develop a general profile of the target populations for the supports and services that it would be assessing. The primary focus of this information was on diagnostic and symptom factors, and their implications in terms of treatment and service needs, challenges to community placement, and risks of re-hospitalization. These activities included:

- Chart audits of a small sample of individuals who had been discharged from ROHCG inpatient units and who required re-admission within 90 days;
- Interviews with social work professional practice leads from the ROMHC and BMHC;
- Interviews with community based mental health and intensive support workers who support individuals discharged from inpatient services to community placements;
- Interviews with service coordination and brokerage personnel, and intensive treatment and support programs for individuals with intellectual disabilities and/or dual diagnosis;
- Participation in multi-stakeholder case conferences regarding community treatment and support planning for individuals with complex needs.

STAKEHOLDER CONSULTATIONS

Case management and community support stakeholders

Consultations were initiated with a range of professional stakeholders providing discharge planning, intensive case management and community support, and other community based services. The primary focus of these consultations was on issues relating to discharge and transitional planning processes, information exchange, service provision and integration, accessibility and general challenges in the community placement and support of individuals with serious and persistent mental illness. These consultations included:

- Interviews with the social work professional practice leads of the ROMHC and BMHC;
- Group presentation and discussion with social work staff of ROMHC and BMHC;

- Questionnaires distributed to social work staff of ROMHC and BMHC;
- Group presentation and discussion with community based mental health workers/case managers;
- Questionnaires distributed to community based mental health workers/case managers;
- Interviews with Ottawa based ACT team leaders/managers;
- Questionnaires distributed to Ottawa based ACT teams;
- Participation in multi-stakeholder case conferences regarding service planning for individuals with complex needs;
- Interviews with drop-in/centre based programs providing a range of services to individuals with mental illness;
- Interviews with Community Health Centres;
- Interview with the Community Care Access Centre;

Housing/Residential Stakeholders

Consultations were initiated with a range of stakeholders providing residential services and support to residential placements for individuals with serious and persistent mental illness. The primary focus of these consultations was on access criteria, service provision, and capacity to serve complex needs and overall issues in systems development. These consultations included:

- Structured interviews with a cross section of domiciliary hostel service providers involved with the City of Ottawa's Housing Branch/Supported Living Services domiciliary hostel program;
- Interviews with City of Ottawa Housing Branch and Supported Living Services program staff;
- Interviews with Homes for Special Care program staff;
- Participation in multi-stakeholder consultation meeting facilitated by the City of Ottawa's affordable housing program;
- Structured interviews with intensive support/rehabilitative housing programs;
- Interview with the Housing Loss Prevention Program;
- Interview with shelter system program staff;
- Participation in the initial session of the Housing Task Force of the Champlain Mental Health Network's Intensive Level Working Group;
- Interview with Community Care Access Centre staff regarding long term care service provision;
- Interview with Royal Ottawa Place personnel;

Consumers/Consumer Advocates

Consultations were initiated with consumers of inpatient and community based mental health services, personnel representing consumer initiated support programs, Patient Advocate/Patient Rights Advisors and the ROHCG Patient Representative. The focus of these consultations was on the nature and extent of communication and collaboration between consumers and service providers in treatment planning and the identification of key issues of importance for consumers with regards to wellness and recovery. These consultations included:

- Interviews with the ROMHC Client Empowerment Council;
- Interviews with Psychiatric Survivors Ottawa staff;
- A focus group targeting consumers of ROMHC interventions;
- A focus group targeting peer support workers involved in Psychiatric Survivors Ottawa's Wellness Project;
- Interviews with the Psychiatric Patient Advocate Office's Patient Advocate and Patient Rights Advisors overseeing ROHCG inpatient services;
- Interviews with the ROHCG Patient Representative.

Consultations with Families/Family Advocates:

Consultations were also initiated with family members of individuals with serious and persistent mental illness and with family advocates. The focus of these consultations was on the nature and extent of collaboration, communication and support extended to family members who are supporting individuals in inpatient and community based treatment, and in identifying their primary concerns regarding the capacity of the mental health system to provide adequate levels of support in both inpatient and community based settings. These consultations included:

- Meetings with the Family Advisory Work Group (FAWG) of the Champlain Mental Health Network;
- Questionnaires distributed to family members through the FAWG's mailing list.

DUAL DIAGNOSIS CONSULTATIONS

Consultations were initiated with individuals and programs involved in the development, brokerage, and provision of services to individuals with dual diagnosis. These scope of these consultations included developmental sector agencies funded by the Ministry of Community and Social Services and mental health agencies funded by the Ministry of Health and Long Term Care. The focus of these consultations was on the capacity of service providers to address the complex needs of individuals with dual diagnosis in both inpatient and

community based settings and the extent to which collaboration and integration exists between ministries in terms of service development and delivery. These consultations included:

- Interviews and participation in systems development meetings with the Eastern Region Network for Specialized Care;
- Participation in Developmental Services Ottawa (transfer payment agency Executive Directors planning committee) meetings;
- Structured interviews with developmental sector transfer payment agencies providing residential support and other service interventions;
- Interviews with developmental sector day program/outreach services personnel;
- Interviews with Service Coordination personnel;
- Interviews with Citizen Advocacy personnel;
- Interviews with personnel from the Dual Diagnosis Service of BMHC;
- Interviews with the ROHCG Dual Diagnosis Consultation and Outreach Team;
- Participation in the Dual Diagnosis Action Group meetings;
- Interviews with the CMHA Ottawa Dual Diagnosis Program;

APPENDIX B

INFORMATION GATHERING TOOLS

The Special Project for Systems Integration developed a number of tools to facilitate its information gathering activities. These include

I. Community-based support worker questionnaire
II. Community support program interview tool
III. Consumer focus group tool
IV. Consumer group interview tool
V. Developmental services residential caregiver interview tool
VI. Family group interview tool
VII. Family questionnaire
VIII. Residential caregiver interview tool
IX. Social work staff questionnaire
X. Transition planning chart audit tool
XI. Treatment and transitional planning tool

A sample of each tool follows.

APPENDIX B

I. COMMUNITY-BASED SUPPORT WORKER QUESTIONNAIRE

Community-Based Agency/Role: ____

1. Are community-based support workers involved in the ROHCG admissions process with regards to providing information regarding the client's mental status leading to admission, de-compensation issues and etc.? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

2. Do frontline/primary workers have access to inpatient staff for ongoing consultation regarding treatment plan development and implementation, community re-integration challenges, target discharge dates and etc.? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

3. Is there a written treatment plan that outlines client, family, inpatient staff and community-based support workers' (ACT, family physician, community psychiatrist, counselor, housing provider etc.) roles and responsibilities in treatment implementation? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

4. Are the community-based support workers involved in identifying and presenting community re-integration planning options in the discharge planning stage? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

5. Does discharge planning address the following issues:

- Housing

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Drug card, medication compliance

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Financial issues (Ontario Works, Ontario Disability Support Program, Canada Pension Plan Disability, and other pensions)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Capacity issues – Public Guardian & Trustee, Substitute decision maker, Community treatment order.

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Vocational issues

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- Identification— birth certificate, SIN, health card, immigration

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

- ADL needs (i.e. home support, personal care needs, etc.)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

6. Do in patient staff provide follow-up support after the patient is discharged? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

7. Are early intervention plans and crisis intervention plans discussed and developed?

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

8. Please identify 3 high-priority issues that impact negatively on the potential for successful community re-integration of ROHCG inpatients:

1. ____
____
____

2. ____
____
____

3. ____
____
____
____

APPENDIX B

II. COMMUNITY SUPPORT PROGRAM INTERVIEW TOOL

AGENCY: DATE OF INTERVIEW:

ADDRESS/PHONE:

STAFF INTERVIEWED (NAME/ROLE):

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1. Overview of range of services provided

2. Staffing: background and education

3. Referral process and criteria for eligibility
   - Criteria for access;
   - Referral process;
   - Supports required to access programs

4. Capacity to serve special needs re:
   - Serious and persistent mental illness
   - Concurrent disorders/dual diagnosis;
   - Behavioural issues;
   - Physical disabilities;
   - Communication disorders

5. Stats:
   - # Referrals refused re. special needs exceeding capacity;
   - # placement breakdown re. extensive special needs

6. Systems issues/gaps and barriers identified

APPENDIX B

III. CONSUMER FOCUS GROUP TOOL

1. In your experience as an inpatient with the ROHCG, how informed and involved did you feel in terms of:

   i. ***Patients Rights*** information:
   - Did anyone speak to you about this? If so, who?
   - If info was given, when and how was information shared?
   - Are there better ways for this information to be shared?

   ii. ***Diagnosis and Treatment*** information:
   - Did anyone explain why you were admitted and what would be done to try to help you?
   - Did you feel you had any input in the treatment you received?
   - Was your treatment plan meaningful to you? Did you feel that the treatment you received actually helped you in your recovery and wellness?
   - Of all the staff you had contact with while you were an inpatient, who do you think was the most supportive to you?
   - Any other comments/concerns?

2. While you were receiving inpatient care, were you able to maintain connections and support from the ***support networks*** that helped you in the community, in terms of:

   i. ***Professionals*** who supported you:
   - ACT teams
   - Doctors/psychiatrists
   - Care providers
   - Others

   ii. Your ***personal supports***:
   - Family members
   - Friends
   - Others

3. When you think about your experience of leaving hospital and ***returning to the community***:
   - On the day you were discharged, what was the most important concern for you, or what did you feel you needed the most? Were you helped with this?
   - As you left the hospital, did anyone help you develop a plan to get through difficult times?
   - While you are in the community, what is the most important thing, or things, that help you stay out of hospital?

4. Have you had any experiences getting help from community hospitals (emergency wards) other than the ROH at times of crisis? What was helpful and what was not?

5. Is there anything that we haven't asked about that you feel is important for us to know, in terms of your experience receiving treatment from the ROHCG?

APPENDIX B

IV. CONSUMER GROUP INTERVIEW TOOL

Note: this tool is intended as a guide for interviews with patient/consumer advocacy groups, with a focus on generalized transitional planning systems issues. It is not intended for interviews with individual consumers regarding their specific transitional planning processes.

Consumer Group/Advocate: ____

Date of Interview: ____

---

1. When consumers are referred to ROHCG inpatient care, are they properly informed (i.e. what information is provided, who provides it, is it adequate) re:

    i. The admissions process
    ii. Treatment model of admitting service
    iii. Anticipated length of stay, issues that impact on community reintegration

2. Do consumers feel that they are appropriately involved in and/or informed of the decision to be admitted to ROHCG inpatient care?

3. Is information provided to consumers regarding the nature of their mental illness, treatment options, and the methods of the treatment program they have been admitted to? Are consumers involved, in a meaningful way, in the treatment and transition planning processes? Are meaningful choices provided?

4. Do treatment plans address issues that consumers feel are important in terms of their ability to return to the community (i.e. symptomatology, medication, activities of daily living, housing issues, vocational/recreational skills, etc.)?

5. Is transition planning part of the initial treatment planning process (i.e. anticipated discharge dates, needs areas to be addressed, etc.)?

6. Are key elements of treatment plans followed through in the course of treatment? Are there issues that are important to consumers that are not addressed in treatment?

7. Do consumers have concerns regarding the role of family members in the admissions, treatment and transition planning processes? Is the input of family members and other personal supports pursued to the extent that the consumers want it to be?

8. When consumers have community-based professional supports in place (ACT, case management, residential caregivers, etc.), are they brought into the admissions, treatment planning and transition planning processes to the extent that the consumers want them to be?

9. Are consumers' physicians involved in the admissions, treatment and transition planning processes to the extent they want them to be?

10. Do treatment and transition plans involve a written component that outlines the responsibilities of all the individuals involved?

11. To what extent are housing needs addressed in transitional planning? Do consumers feel that a meaningful choice is provided?

12. Do transition plans address issues that consumers feel are important in terms of their ability to return to the community, including:

    i. Activities of daily living skills building/supports
    ii. Vocational/rec. needs
    iii. Transportation needs re. rec./voc./medical appointments, etc.
    iv. Medication, drug cards
    v. Financial issues (Ontario Disability Support Program, Ontario Works, etc.)
    vi. Personal documents: health card, SIN card, birth cert., etc.

13. Do transition plans identify crisis prevention and intervention measures, with clearly identified roles of key individuals?

14. To what extent does community reintegration happen in a gradual way, with opportunities to visit housing and community supports prior to transition?

15. To what extent are ROHCG staff involved in supporting consumers after community re-integration has occurred? Is this level of support appropriate?

16. Other issues and/or recommendations?

APPENDIX B

V. DEVELOPMENTAL SERVICES RESIDENTIAL CAREGIVER INTERVIEW TOOL

AGENCY: **DATE OF INTERVIEW:**

ADDRESS/PHONE:

STAFF INTERVIEWED (NAME/ROLE):

---

1. RESIDENCE QUESTIONS:

- Number of homes
- Average # residents per home
- Shared or single rooms
- Crisis/respite beds

2. AGENCY REFERRAL QUESTIONS:

- Access criteria
- Orientation process -- visits, day stays, overnight stays
- Per diem rates/system

3. STAFFING:

- Composition re: ratios, staffing backgrounds/years of experience and professional designations:
- Specialized staffing re: occupational therapy, vocational, recreational, behavioural therapy, dietary, etc.
- Training opportunities/issues re. staffing and resources.

4. **SPECIAL NEEDS POPULATIONS:**

- Capacity re: dual diagnosis, physical/sexual behaviours, physical disabilities, communication disorders, etc.
- Special needs designated beds/homes
- Anticipated service enhancements/developments re. special needs capacity
- Crisis response protocols
- Stats for past year re:
    - Referrals refused for lack of capacity
    - Placement breakdowns due to special needs exceeding capacity
    - Crises requiring emergency department interventions

5. ACTIVITIES & PROGRAMMING:

- In-house programming re:
    - Activities of daily living skill building
    - Vocational
    - Recreational

- Accessibility of community-based programming
- Barriers to accessing community programming (availability, transportation, etc.).

6. MEDICAL/DENTAL:

- How are medications dispensed in homes
- Issues re. access to family doctors, dentists, psychiatric support, community health centres, and other specialized primary health services
- # Referrals that do not have designated doctor/dentist

7. CONSENT AND CAPACITY:

- Process for substitute decision makers, public guardian and trustees regarding treatment decisions and financial matters.
- Overall level of family/substitute decision maker/public guardian & trustee involvement

8. SYSTEMS ISSUES:

- Significant systems issues that impact on capacity to provide support to special needs populations
- Other systems issues

APPENDIX B

VI. FAMILY GROUP INTERVIEW TOOL

Note: this tool is intended as a guide for interviews with consumer family advocacy groups, with a focus on generalized transitional planning systems issues. It is not intended for interviews with individual consumers regarding their specific transitional planning processes.

Family Group: ____

Date of Interview: ___________________________

---

1. To what extent are family members involved in the ROHCG admissions process, with regards to:

   i. Issues of confidentiality and/or other barriers
   ii. Providing historical information regarding the patient's psychiatric condition, strengths and needs, support systems and etc.
   iii. Receiving information regarding the reason for and terms of admission
   iv. Receiving information regarding patient rights/patient advocate

2. To what extent are family members provided general information regarding institutional operations (telephone contacts, visiting hours, privilege levels, parking , etc.)

3. Are family members given a key contact person to address ongoing concerns regarding treatment and/or any other issues with respect to the patient's care? Do family members have appropriate access to treatment staff (i.e. psychiatrists, nursing staff, etc.) to address concerns and/or field questions?

4. To what extent do family members receive information regarding the patient's initial diagnosis, treatment options and the treatment planning process?

5. Do family members receive information regarding supports that are available to them, either through the ROHCG or community based?

6. To what extent are family members involved in the early treatment and transition planning processes? Are there barriers to their involvement? If family members are involved in the treatment and transition planning processes, how does this take place (what type of consultation, who is present, what role does family asked to play, etc.)?

7. To what extent are family members involved in supporting the ongoing treatment process?

8. Do treatment and transition plans involve a written component that outlines the responsibilities of all the individuals involved?

9. To what extent is family members' contact with the patient facilitated and supported by inpatient staff?

10. What are the primary concerns that families have with regards to community re-integration? To what extent does treatment and transition planning address these issues?

11. To what extent do families play a role in supporting community re-integration?

12. From the family's perspective, to what extent are community resources activated to support re-integration? Are these supports adequate?

13. Is contact between family members and community supports facilitated? If so, what is the nature of this contact?

14. To what extent are housing needs addressed in transition planning? Do families feel that meaningful choice is provided?

15. Do transition plans identify crisis prevention and intervention measures, with clearly identified roles of key individuals?

16. To what extent does community reintegration happen in a gradual way, with opportunities to visit housing and community supports prior to transition? Are families involved in supporting this process?

17. To what extent are ROHCG staff involved in supporting the patient and their family supports after community re-integration has occurred? Is this level of support appropriate?

18. Other issues and/or recommendations?

APPENDIX B

VII. FAMILY QUESTIONNAIRE

(Please note: if you require more space for comments than is provided, please feel free to use separate sheets of paper).

1. Please identify the ROHCG program(s) that your family/family member has been involved with:

2. In your family's experience, does the individual being admitted to ROHCG inpatient care provide consent for the sharing of information with family members? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

3. When an individual is being admitted to ROHCG inpatient care, are family members asked to provide information about the individuals' psychiatric history and presenting condition/concerns? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was the individual agreeable to you providing this information: ___Yes ___ No

Comments:

4. Are family members given information regarding the patient's initial diagnosis, terms of admission and treatment options? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

5. Are family members given general information regarding ROHCG institutional operations (visiting hours and phone contact, patient privilege levels, parking, etc.). (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

6. Are family members given information regarding supports that are available to them, either through the ROHCG or community based? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

7. Are family members given a key ROHCG contact person to address ongoing concerns regarding treatment and/or any other issues with respect to the patient's care? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

8. While the individual is in treatment, do family members have access to treatment staff (i.e. psychiatrists, nursing staff, etc.) to address concerns and/or field questions? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

9. Are family members involved in treatment planning? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Please add comments regarding how family members' involvement is supported/not supported:

10. Does the treatment plan identify the supports family members can provide to the treatment process? (Please circle one);

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

11. Do family members receive a written treatment plan that identifies key individuals involved in treatment and their roles/commitments? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

12. Are individuals with identified roles in the treatment process held accountable for following through on their commitments? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

13. Is contact between family members and the patient facilitated and supported by inpatient staff? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

14. Please identify issues that you feel are most important to consider when planning for re-integration of an inpatient to the community.

15. Are these issues addressed in transition/discharge planning? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

16. Are families asked to play a role in supporting community re-integration? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for ROHCG to provide information granted by the patient: ___Yes ___No

Comments:

17. From the family's perspective, are adequate community resources available to support re-integration? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

18. From the family's perspective, to what extent are community resources that are available included in the re-integration plan? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

19. Is contact between family members and community supports facilitated? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Was consent for this contact granted by the patient: ___Yes ___No

Comments:

20. Are meaningful choices for housing available to patients planning for community re-integration? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

21. Are housing needs addressed in discharge/transition planning? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

22. Does community reintegration happen in a gradual way, with opportunities to visit housing and community supports prior to transition? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

23. For patients returning to the community, do discharge/transition plans identify crisis prevention and intervention measures? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

24. Are post-discharge crisis prevention and intervention options adequate? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

25. ROHCG patients who have been discharged often access community hospital emergency services in times of crisis. From the family members' perspective, are the interventions provided in these settings adequate? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

26. Are ROHCG staff involved in supporting the patient and their family supports after community re-integration has occurred? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

27. Are there any other issues or concerns that you would like to note?

Thank you for taking the time to complete this questionnaire!

APPENDIX B

VIII. RESIDENTIAL CAREGIVER INTERVIEW TOOL

AGENCY: **DATE OF INTERVIEW:**

ADDRESS/PHONE:

STAFF INTERVIEWED (NAME/ROLE):

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1. RESIDENCE QUESTIONS:

How many residents?
Number of single rooms
Number of people sharing
Weekends out vacation/absence policy for retention of bed

2. AGENCY REFERRAL QUESTIONS:

Who are you able to provide support to?
Referral process?
Orientation Process –visits, day stays, overnight stays, 2-3 days, weekend stays?
Waiting list?

3. STAFF COMPOSITION: RATIOS, STAFFING BACKGROUNDS/YEARS OF EXPERIENCE AND PROFESSIONAL DESIGNATIONS:

Does staff composition include: nurses, social workers, occupational therapy, recreational therapy, behaviouralists, counseling, developmental specialists, addiction counselors, anger management specialists, mental health counselors, dieticians, physicians, psychiatrists, psychologists, primary key contact for discharge/transition?

Number of support hours?
Variance of hours of support (After hours, overnight, evenings, weekends, holidays)?

Staff ratio during the day
Staff ratio during the evening
Staff ratio overnight
Staff ratio weekends/holidays
Staff composition during these shifts

4. **SKILLS & EXPERTISE DISCIPLINES: OPPORTUNITIES FOR STAFF DEVELOPMENT AND SKILLS DEVELOPMENT?**

Opportunities/expectations regarding training in: nursing, counseling: suicidal ideation and attempts, self harm behaviour (cutting, burning), addiction, eating disorders, developmental, behavioural, anger management, assertiveness, sexual behaviour counseling, sexual assault counseling, suicide intervention skills, crisis intervention skills, symptomatology awareness, nutrition, exercises, recreology and leisure, occupational and employment, pastoral care, foot care, literacy etc.?

5. **FAMILY INVOLVEMENT:**

Sharing of information, education, advising of current status situations, role of the substitute decision maker?

6. **SAFETY:**

Crisis intervention skills, early intervention plans, suicide intervention training and responses to suicidal ideation and attempts, self harm behaviour. Posted rules regarding verbal and physical aggression, medication compliance issues, smoking issues (allowed, rationed amount, special rooms), dealing with wandering behaviour?

7. **DISABILITIES/SPECIAL NEEDS:**

Accessibility issues (stairs, elevators, room for wheel chairs and walkers). Ability to support vision, hearing, mobility, incontinence, wheelchair transferring, personal care (bathing, toileting, dressing, feeding) sexual behaviour (flashing, undressing, masturbating), aggressive behaviour (verbal and physical), addiction issues (drugs, alcohol, prescription drugs), eating disorders. How are these people assisted?

Level of support able to provide (i.e., accompaniment, monitoring, counselling, treatment, short/long term support)?

8. **MEDICATIONS:**

Meds dispensing regime, who and when, what happens if one refuses meds? How many times before the doctor is notified? What is done to motivate meds compliance? How are people taught to have control over their meds, their own meds taking, etc?

9. **ACTIVITIES & PROGRAMMING: STRUCTURE DURING THE DAY**

Besides meals and sleep times, programming regarding individual activities, self-care activities, room care activities, meal preparation, laundry, shopping, personal health care, communication skills, interpersonal relationships, anger management, exercising, meds taking, money management, leisure activities (i.e. reading, knitting, sewing etc.?

Other programs and staff expertise that can be accessed (i.e. activities of daily living assessments, life skills training, day programs, volunteer/employment support)

10. SOCIAL/GROUP ACTIVITIES

Outings, trips, camping, museums, shopping, movies, day programs, arts & crafts, bingos, cards, music, peer support and mentoring, volunteering?

11. FINANCIAL:

Daily, weekly, bi-weekly, monthly allowances? Public guardian and trustee applications, assistance with applying for needed pensions, assist with income taxes, securing a bank account?

12. TRANSPORTATION:

Accompaniment to appointments and activities, arrange for volunteer drivers, para transpo, bus tickets, taxis, arrange for bus passes, teaching bus taking?

13. OTHER ISSUES RELEVANT TO PLACEMENTS:

Reciprocal information exchange, ability to assist with short term stabilization issues i.e. acute care admissions, respite care, long term care placements, other supportive living arrangements?

14. SYSTEMS ISSUES IDENTIFIED:

APPENDIX B

IX. SOCIAL WORK STAFF QUESTIONNAIRE

Inpatient Unit/Program: ____

1. What is the range of roles assumed by social work staff on the treatment team (for example, individual/group counseling, family counseling, discharge planning, and etc.)?

2. At what stage in the inpatient treatment process does discharge planning begin?

3. To what extent are social workers able to facilitate the involvement of the individual's support network (family, residential care providers, community supports such as Case Management and ACT, etc.) in the treatment and discharge planning process? Are there barriers to this involvement? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

   Comments:

4. To what extent does the discharge process occur in a gradual manner, with opportunities for day/overnight visits to community placements prior to discharge? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

   Comments:

5. Are social workers able to provide short-term transitional support to individuals following discharge? If so, how does this take place? If not, what are the primary barriers to this role? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

   Comments:

6. To what extent are early intervention plans and crisis intervention plans incorporated in the discharge planning process? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

7. What issues regarding inpatient symptomatology and special needs present the most challenges to discharge planning related to securing residential placements and community support services?

8. To what extent is inpatient treatment able to address the concerns identified above, with regards to preparing the individual for discharge? (Please circle one):

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

9. To what extent are social workers able to access community-based resources to support discharge planning, with regards to:

- Housing

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Access to family doctor/dentist

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Financial issues (Ontario Works, Ontario Disability Support Program, Canada Pension Plan Disability, and other pensions)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Vocational programming

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Recreational/social activity programming

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Activities of daily living needs (i.e. home support, physical/personal care needs, etc.)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Community based professional supports (case management, ACT, counseling, etc.)

Always	Nearly Always	Often	Sometimes	Now and Again	Nearly Never	Never

Comments:

- Other:

10. Please identify 3 high-priority issues that impact negatively on the potential for successful community re-integration of ROHCG inpatients:

1. ______________________________

____

2. ______________________________

____

3. ______________________________

____

____

APPENDIX B

X. TRANSITION PLANNING CHART AUDIT TOOL

Patient: ____________________ **D.O.B.:** ________ **Gender:** M___ F___

Admission/Discharge history:

DIAGNOSIS/PRESENTING CONCERNS: (Identify by admission/discharge period)

TRANSITION RISK FACTORS SCREEN:

	At current admission	Previous discharge	Previous admission
1. Requires arrangement of residential placement different from that at admission.			
2. Requires financial discharge planning.			
3. Difficulty in impulse control (physical/verbally aggressive, suicidal, fire setting).			
4. History of serious and prolonged impairment in performance at work, school, or in activities of daily living.			
5. Has previously left this or other facility against medical advice.			
6. Numerous and/or lengthy past psychiatric hospitalization.			
7. Non-voluntary legal status.			

8. Serious medical condition or physical disability.

9. Substance abuse issues.

10. Member of family where there has been recent actual or suspected physical abuse.

11. Patient or family is in process of separation or divorce.

12. Diagnosed with mild or greater mental retardation.

13. Suspected organic mental disorder.

14. Has no involved or available family/significant other (including patients who refuse to permit family involvement).

15. Patient/family has history of non-adherence to discharge plans (including non-compliance with medication).

16. Patient's immediate family has another member with serious, current mental or medical illness.

17. Last discharge against medical advice.

APPENDIX B

XII. TREATMENT AND TRASITIONAL PLANNING

1. Multi-disciplinary inpatient team members involvement in assessment/treatment/ transition planning (extent to which plan addresses bio-psycho-social spectrum)?

2. Patient receiving services from ACT at point of admission? If so, ACT involved in initial assessment (information gathering) and treatment/transition plan development (roles/responsibilities in ongoing treatment)?

3. Patient and/or family provided info./education/support regarding mental health system, nature of patient's condition and course of treatment, responsibilities of key players in process, and key contacts/sources of information and support?

4. Patient and/or family/significant supports involved in initial assessment (information gathering) and treatment/transition plan development (roles/responsibilities in ongoing treatment)? Patient has opportunity for meaningful input and provided meaningful choices? Patient/family have identified roles/responsibilities in transitional process?

5. Community based supports/practitioners previously involved with patient (family physician, caregivers, community support agencies etc.) involved in initial assessment (information gathering) and treatment/transition plan development (roles/responsibilities in ongoing treatment)? To what extent does transition plans identify:
   i. roles/responsibilities in transitional support
   ii. mechanisms for timely information sharing
   iii. identification of key contact persons for all parties involved

6. Transition risk factors addressed in treatment plan?

7. Treatment and transition plan incorporates elements of psycho-social-rehabilitation?

8. Elements of inpatient treatment plan and other pre-existing intervention plans carried forward in transition plan?

9. Treatment plan includes anticipated date/time frame of transition, and patient, family, community supports informed?

10. Transition plan identifies relapse prevention measures, early warning signs of de-compensation and appropriate interventions and responsibilities of all parties. Also includes parameters/criteria for readmission if necessary, and key roles of all players?

11. Transition plans addresses any issues of cultural sensitivity?

12. Final plan written as contract between all stakeholders and patient, signed by all relevant parties?

13. Transition occurs gradually, with opportunities for patient/family to tour/meet with community care and support providers prior to actual engagement?

14. Transition involves follow up support from hospital staff in early stage of transition?

15. At discharge, patient referred for ACT supportive interventions?

16. Patient engaged with mental health service peer/consumer advocacy and support?

17. Plan assures necessary medications available in early stage of transition to community. Medications prescribed covered under provincial drug formulary?

18. Current status report re. discharge planning, barriers to community placement and etc.?

19. Other?

(This tool was adapted from Christ et. al, 1994).

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