



NADD ONTARIO

Select Committee on Mental Health and Addictions,
October 2009

**Dual Diagnosis:
System design for individuals with developmental
disabilities and mental health needs**

Jim Johnston
Board Member
NADD Ontario
President, Meta Centre

Susan Morris RSW
President, NADD Ontario
Chair, National Coalition on Dual Diagnosis
Clinical Director, Dual Diagnosis Program, CAMH
For information: Susan_Morris@camh.net

Presentation Objectives

- Introduce NADD Ontario
- System and service level integration – what works
- Recommendations for the whole system
- What this means for families



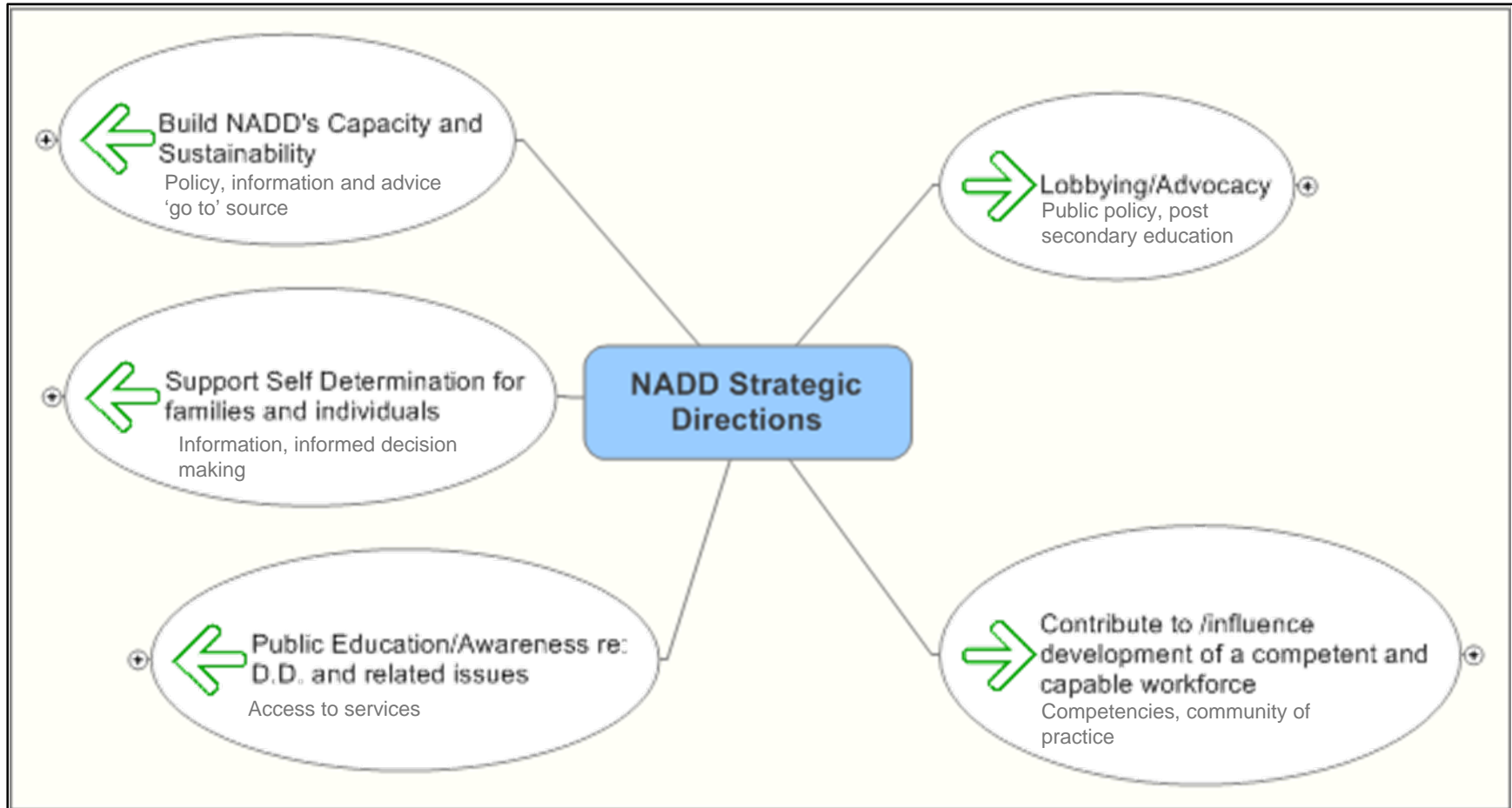
NADD Ontario Mission

To advance mental wellness for persons with developmental disabilities through the promotion of excellence in mental health care

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



NADD Ontario Initiatives



Of 275,000 persons with developmental disabilities in Ontario*

- 38% have mental health difficulties
- 43% undiagnosed health problems
- 25% unattended dental needs
- Children with disabilities 5 x more likely to experience abuse
- Half of adults living in community are prescribed psychiatric medications with no known associated psychiatric illness
- 77% live in poverty
- 10 – 50 % are homeless
- 1 baby is born every day with Fetal Alcohol Syndrome
- 30% have a friend who is not family or paid caregiver (UK)*

Conceptual model to approach System Design

■ **System level integration**

- policy, funding, leadership, information management, research and knowledge exchange

■ **Service level integration**

- at the client level - collaborative models of care: networks, interprofessional teams

System level integration – current examples of what works

1. **Enabling Government Policies**

- **Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis** (MOHLTC and MCSS, December 2008)
- **Human Service and Justice and Justice Coordination Committees – MOHLTC transfer funding to MCSS for 12 case managers**

System level integration cont'd

2. Human resources - professional preparedness through training and education

- **Primary Care Guidelines and Training** – jointly funded by MOHLTC and MCSS (Sullivan et al, 2006)
- **HealthForceOntario Perspectives Project** – IPE student training in developmental disabilities and dual diagnosis at U of T, York, GBC. (perspectives@camh.net)

3. Accurate data and research

- **Community University Research Alliance (CURA)** – 2 projects with self advocate and family involvement in research (<http://3Rshumanrights.com>, www.seocura.org)

Service level integration – current examples of what works

4. Help for families, friends and caregivers

- Individualized planning tools, support circles, crisis prevention and support plans

5. Local/regional networks of care and agreements

- 4 Community Networks of Specialized Care (MCSS,2006) (<http://www.community-networks.ca/>)
- Coordinated and/or shared intake procedures across sectors and the continuum

6. Self advocate and family involvement in training and education

- Self advocates and families as participants and actors in medical student and psychiatry training (Ouellette-Kuntz et al, 2003, Burge et al, 2008)

Recommendations for the whole system:

Individuals with a dual diagnosis represent the worst case scenario for how the system fails people with complex needs.

1. **Flexible system structure:**

- Integration at both the system and service levels – requires consistent ongoing interministerial structures
- Systems are designed to facilitate flexibility in movement of people in any direction
- Resources for system and service level integration - Facilitators/case managers/system navigators who hold an integrated understand of the complexity

Recommendations cont'd

- **2. Funding formula within health that de-emphasizes hospital beds and recognizes the cost of community care**
 - Adequate resources to provide community based interprofessional care, housing, support and employment

- 3. Development of a competent workforce**
 - define minimum care standards and benchmarks for training programs
 - investment in human resource knowledge and skills training and education that establishes career paths

- 4. Continuum of services**
 - including a tiered approach to make the best use of the most expensive intensive/specialized resources

What this means for families

- Coordinated Assessments
- Quality measures for Programs
- Salaries adequate to attract and keep skilled workers
- Assurances that supports will be there when families are unable to provide support
- Better education of doctors, psychiatrists and other support workers.
- Flexibility
- Respect for their children