



DUAL DIAGNOSIS: Collaborating for Solutions

June 9, 2010

Forum Summary

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Overview

The Dual Diagnosis Forum, held on June 9, 2010, was co-sponsored by:

- The Community Networks of Specialized Care – Toronto
- The Toronto Central Local Health Integration Network
- The Toronto Human Services and Justice Coordinating Committee

The Forum was organized in order to bring together directors, managers, planners and policy makers from across the mental health, developmental services, justice and other associated sectors to engage in discussion and strategy development, with a focus on improvements in service delivery for adults with a dual diagnosis. Eighty people registered to attend the Forum; of those, 64 participants were in attendance. Please see Appendix A for the Forum Agenda and Appendix B for a list of Participants.

In December 2008 the “Joint Policy Guideline for the provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis in Ontario” was released. Although not substantially different than the 1997 guidelines, two new structures were in place: the Local Health Integration Networks (LHINs) and the Community Networks of Specialized Care (CNSCs). The purpose of the guideline is to provide a framework for the planning, coordination and delivery of community mental health and developmental services and supports that will promote better access to both sectors for persons 18 years and older with a dual diagnosis.

The Community Networks of Specialized Care were set up to enhance service to adults with a developmental disability who need specialized care for co-existing mental health and/or behavioural issues. They were created to be accessible – so that people and their caregivers/families can access the clinical services they need, when and where they need them. In addition, services are coordinated and integrated so that the services and supports from a number of programs, organizations and sectors are working together with people and their families to make a difference. Accountability was also important, so that we know the networks are actually making a difference.

The Toronto Central Local Health Integration Network (LHIN) is responsible for planning, coordinating and funding key health care services in central Toronto for approximately 1.14 million people. The Toronto Central LHIN funds 177 health service providers including hospitals, the Toronto Central Community Care Access Centre, community support services, Community Health Centres, mental health and addictions agencies and long-term care homes. In addition to serving our local community, health service providers in the Toronto Central LHIN provide specialized health services to a large number of Ontarians who live in other LHINs.

In 2006, the government of Ontario established Local Health Integration Networks as part of a plan to transform health care in the province. The LHINs were created to improve the performance of health care in Ontario by enabling and driving changes that reflect the needs of the province’s diverse communities.

The Ministry of Health and Long-Term Care sets the policy directions, key priorities and performance targets for health care in the province. With input from local health care providers, consumers, and communities, the LHIN brings these priorities and targets to life at the local level – as services, programs and projects in hospitals, community care access centres, family physicians’ and health specialists’ clinics, community programs and long-term care homes.

The Toronto Central LHIN works with the 13 other LHINs to build a consistent and cohesive provincial system of health networks. Together, the LHINs will create a strong and sustainable health system that keeps Ontarians healthy, gives everyone access to the health options they need, and delivers the best value for taxpayers’ health care dollars.

Provincially, all of the CNSCs and the LHINs met to discuss the implementation of the Policy guidelines; currently there is a wide range of collaboration across the province. In Toronto the Network and the Toronto Central LHIN co-sponsored an initial meeting at Christie Gardens in the spring of 2009, inviting LHIN and developmental service partners to a launch of the guidelines.

In order to keep the momentum going, a cross-sector planning group was established to work to plan for the June 9 forum. Part of the planning involved the development of a framework, which was proposed:

Vision from the guideline – community mental health and developmental services for persons with a dual diagnosis and their families will be integrated, coordinated and operate responsively and proactively both within and across sectors

Relationship – three sectors: Justice, Mental Health and Developmental Services

Knowledge – panel to provide information, breakout groups to enhance during discussion

Action – generated from the participants

Collaborating for Solutions: Opening Remarks

The Dual Diagnosis Forum opened with remarks from Karen Meehan, Community Programs Manager, Developmental Services, Ministry of Community and Social Services (MCSS) and Barbara Everett (Toronto Central LHIN Board Member) regarding the importance of working more collaboratively in order to make a difference for individuals with a dual diagnosis, and for their families.

Jim Johnston, a family member, showed a video clip about his family’s experience in supporting an individual with a Dual Diagnosis (DD). He commented that, as a parent, it is most important to find someone who can guide you to the right resources and programs – “how to find out how to find out”. He noted that “if you don’t have an advocate, the journey becomes much more difficult”.

Context for the Day: Why Collaborating Matters

Jenny Carver, Forum Facilitator, showed a PowerPoint presentation – Collaborating for Solutions – to provide Forum participants with an overview of the facts about Dual Diagnosis, the ‘intersects’ across many sectors which are required in order to effectively support persons with a dual diagnosis, as well as the issues, challenges, and the vision for the future. The presentation covered a number of elements, including:

- The roles and functions of the Local Health Integration Networks (LHINs), Ministry of Community and Social Services (MCSS) Regional Offices, and the Community Networks of Specialized Care (CNSCs) given the Joint Policy Guideline which was updated in 2009 (see Appendix F). The Guideline reflects the structural changes in both ministries (i.e., LHIN’s as Regional system managers and development of CNSCs across the province) and builds on the significant collaboration that has been underway for many years in both sectors. The new Guideline will be a strong foundation for ensuring delivery of services across the continuum and for developing collaborative practices at the individual, program and system levels.
- The importance of understanding the working language and culture of each of the sectors involved, through collaboration and information and knowledge sharing. One small example is the use of within-sector acronyms. See Appendix E for a full listing and interpretation of acronyms used in this document.
- The current pathway (based on a Clinical Decision Tree: see Appendix C) to clinical assessment and responses, and the potential breakdowns if appropriate service responses are not available.
- The vision: Community mental health and developmental services for persons with a dual diagnosis and their families will be integrated, coordinated, and operate responsively and proactively both within and across sectors.

The Facts about Persons with a Dual Diagnosis

The Facts: What is Dual Diagnosis?

Dual diagnosis in this context applies to a person who has a developmental disability and mental health needs.

The Facts: Intersects with the Mental Health System

It was noted that for people with a developmental disability and mental health needs and/or challenging behaviours, there are many intersects with the mental health system. The facts about this population related to physical health and mental health issues and vulnerabilities¹, were outlined including:

¹ Central Region NSC (2007); Emerson & Hatton (2007); Bryson et al (2007); Cooper et al (2007); Sondenaa et, (2008); Raina (2010); Yu & Atkinson (1993); Kuntz & Bielska (2009); Emerson (1987); Bouras (1999)

- At 2.5% prevalence, there are between 20,000 and 30,000 (demand prevalence is estimated between 2% and 3%) individuals with a developmental disability living in the Toronto Central LHIN (prevalence vs. service population).
- Of this population, 38% or 10,000 would be expected to have a mental health need and/or challenging behaviour including 18% DSM IV diagnosis.
- Many are ‘hidden populations’, either being fully supported by burdened families, on the street or in the justice system.
- Children ages 5 – 15 with developmental disabilities are six times more likely to exhibit a mental health problem than kids without a developmental disability.
- Older adults have a higher rate of overall psychiatric illness compared to the younger group (62% vs. 44%, so), as a result of higher rates of dementia, anxiety, and history of depression.
- Between 8 and 25% of developmentally disabled persons have an ASD diagnosis.
- People with dual diagnosis accounted for 2.5% of general hospital mental health admissions and 13% of regional psychiatric hospital admissions.

The Facts: Intersects with Primary Health Care System

It was noted that there is a higher incidence of co-morbid physical health issues among this population that often go untreated in addition to genetic syndromes and correlated mental health disorders². As noted below, un-diagnosed and untreated medical concerns lead to behavioural concerns and interaction with the justice and mental health systems if not managed.

- Individuals with developmental disabilities have a higher incidence of medical conditions than the general population.
- 49% of patients with dual diagnosis in tertiary-level mental health care were noted to have “medical concerns” (62% of inpatients and 43% of outpatients).
- 12% of adults with developmental disabilities referred for psychiatric treatment had unrecognized medical conditions that accounted for presenting behaviours, most often aggression.
- 75% experienced at least one medical problem that was undiagnosed or under-treated, most often epilepsy (50%) and often chronic pain (10%).

² Kerr (2006); Hurley et al (2003); Lunskey et al. (2003); Kastner, Walsh, and Fraser (2001); Ryan and Sunada (1997)

Table 1: Co-morbid Medical Issues³

Co-morbid Medical Issue	Prevalence Range Among Persons with a Developmental Disability
Cardiovascular disease	6.7 – 55.2 %
Diabetes	1.6 – 9%
Obesity	29 – 50%
Seizure disorder	9 – 40%
Dental	
Caries	24 – 56%
Gingivitis	60 – 80%
Respiratory Illness	
Community based	1.5 – 5.1 %
Institution-based	10 – 33%

The Facts: Genetic Syndromes and Correlated Mental Health Disorders⁴

Many of the syndromes associated with developmental disability are correlated with specific behavioural and mental health presentations and diagnoses (see Table 2 below).

Table 2: Genetic Syndromes and Dual Diagnosis

Syndrome	Aggression	Self-Injury	Anxiety Disorder, Phobias	Alzheimer's Disease	Depression, Mania, Bipolar Disorder	Schizophrenia
5p	X	X				
Prader-Willi	X	X	X		X	
William	X		X		X	
Smith-Magenis	X	X				
Lesch-Neyhan		X				
Turner			X			
Fragile X		X	X		X	
22q11 deletion (velocardiofacial)					X	X
Down			X	X	X	
Cornelai de Lange		X				
Rett Syndrome		X				

³ AAMR (2002); Deb et al (2001); Espie et al (2003)

⁴ Dykens et al (2000)

The Facts: Sensory Impairments⁵

Prevalence of co-morbid sensory impairments (hearing and/or visual impairment) is higher among persons with a developmental disability⁶, including:

- Bilateral hearing impairments required hearing aids: 32%
- Rate of hearing loss in adult community sample: 66%
- Severe visual impairment: 13%
- Combined sensory impairment: 3% (in mild/moderate); 20% (in severe/profound)

The Facts: Negative Life Events⁷

- The incidence of negative life events is higher in this population, underscoring that experiences of maltreatment, neglect, undetected Post Traumatic Stress Disorder (PTSD) (see Table 3 below) and socio-economic deprivation increase the risk of mental health and health co-morbidities for people with a developmental disability⁸.
- 48% of children with dual diagnosis had been exposed to two or more adverse life events (compared to 24% of typically developing children).
- 34% were living in ‘unhealthily’ functioning families (compared with 18% of typically developing children).
- 25% of adults had experienced seven or more negative life events in the past two years.
- Persons with dual diagnosis are at increased risk for experiences of maltreatment and neglect, undetected PTSD.

Table 3: Exposure to Negative Life Events Among Children With and Without Developmental Disabilities⁹

Negative Life Event	Children with developmental disabilities	Children without developmental disabilities
Primary carer separated from partner	40%	31%
Child hospitalized	31%	17%
Primary carer or partner in trouble with police	11%	6%
Close friend of child has died	10%	6%
Bereavement in immediate family	5%	3%
Child has witnessed severe domestic violence	4%	2%

⁵ Evenhuis et al (2001); Lowe & Temple (2002)

⁶ Evenhuis et al (2001); Lowe & Temple (2002)

⁷ Hamilton et al (2005); Emerson & Hatton (2007); Hersen (1989); Balogh et al (2001; 2007)

⁸ Hamilton et al (2005); Emerson & Hatton (2007); Hersen (1989); Balogh et al (2001; 2007)

⁹ Emerson & Hatton (2007)

Negative Life Event	Children with developmental disabilities	Children without developmental disabilities
Physically abused	2%	<1%
Sexually abused	1%	<1%

The Facts: Intersections with the Justice/Legal System¹⁰:

- Between 9% and 15% of people with a mild developmental disability will have been arrested at least once, and rates are substantially higher for individuals with dual diagnosis.
- The majority of individuals with developmental disabilities who re-offend will have a dual diagnosis.

Persons with a dual diagnosis:

- Are unlikely to benefit from conventional programs designed to address offending behaviour
- Are targeted by other prisoners when in custody
- Present numerous difficulties for the staff who work with them, especially when these staff often lack proper training
- Seldom have access to specialized resources
- Are often ‘caught’ in the justice system

The Facts: Mental Health and Justice Intersects¹¹

- From a sample of patients with a dual diagnosis at a mental health facility, 30% of inpatients had had legal involvement; 14% of outpatients had had legal involvement.
- Those with legal involvement were more likely to use substances, to have a diagnosis of psychosis and/or impulse control disorders.
- Inpatients with forensic involvement had an average length of stay in hospital 10 times greater than those without forensic involvement.
- There were equal numbers of male and female, which is not consistent with the general justice system age breakdown.

¹⁰ Central Region NSC (2007); Sondenaar et al (2008); Raina et al (2010); Emerson (1987); ‘No One Knows’ (2009); Morris (2009)

¹¹ Central Region NSC (2007); Sondenaar et al (2008); Raina (2010)

The Facts: Those who Intersect with the Justice System¹²

The typical profile for an offender with a developmental disability:

- A young male
- With a number of social and psychological disadvantages
- More likely to be single compared to non-disabled peers
- Belong to a minority group
- Has a history of imprisonment
- Has experienced institutionalization
- Experienced abuse and neglect as a child
- Has come from a disrupted family
- Has attended a segregated school
- Has had unstable accommodations and lifestyle

The Facts: Intersects with the Justice/Legal System¹³ and Behavioural Crisis and Use of ER¹⁴

Justice system intersects are highly related with the behavioural issues associated with individuals with a dual diagnosis and/or developmental disability and challenging behaviours.

- Of 525 individuals with a dual diagnosis who experienced behavioural crisis:
 - 16% had previous trouble with the law
 - 2.5% fire setting
 - 9.4% sexual deviance
 - 16.7% used 9-1-1
 - 19% resulted in ER visit

Predictors of Visits to the Emergency Room¹⁵

It was noted that there are several predictors of visits to the Emergency Room by people with a dual diagnosis, based on recent findings from an intensive research study of Emergency Room visits by persons with a developmental disability:

- The person has previously been to the ER. (This means we already know who is likely to go and therefore we can take proactive steps to intervene through development of integrated crisis plans).

¹² Glaser and Florio (2004); Glaser & Deane (1999); Hayes (1991)

¹³ Morris (2009)

¹⁴ Lunsky et al (in process)

¹⁵ Lunsky et al (2010)

- Life events within the past year (change in client's primary staff/worker, move of house or residence, change in roommates) – this is particularly true for those who go to the ER for behavioural crises. Again, proactive steps can be taken around times of transition when individuals are likely to be more vulnerable to disturbance related to loss and change.

The Facts: Substance Use¹⁶

- Five per cent of individuals with borderline IQ or mild developmental disabilities living in the community and known to developmental disabilities services, use illicit drugs and alcohol.
- There are a number of correlated variables that link to substance misuse in individuals with developmental disabilities, including:
 - An increased risk of violent behaviour and offences
 - More physical health problems
 - Exploitation by others
 - Co-morbid mental health problems
 - Increased risk of homelessness

The Facts: Some Service and Supports Intersects – Service-related Issues¹⁷

- Fifty-three per cent of the sample of forensic-involved tertiary care Dual Diagnosis patients had no daytime activity; 66% in supported living, 18% independently, many inadequately housed/homeless, only 16% with families.
- Persons with a Dual Diagnosis do not access Early Intervention in Psychosis services in the mental health sector; in Ontario ACT teams, 5.7% of clients have a dual diagnosis (excluding dedicated team) as do 10.8% of waiting list clients, despite identification of persons with a dual diagnosis as a priority SMI population¹⁸.
- Persons with a dual diagnosis who are higher functioning find the cultures of both the developmental services and mental health sectors a poor fit for them.

Who are the People with a Dual Diagnosis?: Determinants of Health¹⁹

- Undiagnosed health problems: 43%
- Dental needs: 25% untreated
- Fetal Alcohol Syndrome: one person born every day
- Child abuse: five times more likely

¹⁶ Central CNSC (2007); Gress & Boss (1996); Pack, Wallander, & Browne (1998); Doody et al. (2000); McGillivray & Moore (2001)

¹⁷ Sondena et al (2008); Raina (2010); Burge (2010)

¹⁸ Burge (2009)

¹⁹ Morris (2009)

- Sexual abuse in women: 25 – 33% +
- Prescribed psychotropic medications: 50%
- Live in poverty: 77%
- Homeless or inadequately housed: 10 – 15%
- Have friendships (outside of family or paid caregiver): 30% (UK)

Why Must We Collaborate?

The overarching rationale regarding the requirement to collaborate was outlined. Persons with a Dual Diagnosis who intersect with mental health, health, emergency services, addictions, homelessness and community support services:

- Have complex stories, requiring understanding, assessment and appropriate treatment, and integrated support arrangements to support community participation
- Could, in many cases, have avoided the ‘long journey’ through sometimes highly restrictive environments, to assessment, treatment and support with appropriate access to specialized resources and collaborative delivery of supports and services, not available through one sector

What Families Continue to Ask For²⁰

- Coordinated assessments.
- Accreditation or other measures of quality.
- Recognition by government that workers in this field must be highly skilled and paid.
- Access to case management support that can help the family navigate both sectors.
- Assurances that services will be there when families can no longer support their children.
- Better education for medical and support staff in the field of dual diagnosis.
- Flexibility, including individualized funding.
- Finally, and most importantly, respect for our children – having them seen as valued members of society.

It was emphasized that individuals with a Dual Diagnosis, and their families, need all of us to collaborate for solutions because:

- Issues can be complex.
- Collaborative service responses are needed from many sectors’ services.
- Staff in all these sectors need to have a working knowledge, skills and comfort level with this population.

²⁰ Johnston (2009)

- Specialized expertise needs to be available.
- It is our moral obligation, so that persons with a dual diagnosis can live a life that has meaning, fully included and accepted as community participants. Not responding to mental health and health issues effectively creates significant barriers to support and participation.

Articulating the Challenges to Collaboration in a Complex, Sectored World

Round Table – Experiences and Perspectives

A Round Table discussion provided Forum participants with real life stories relating to cross-sectoral responses at the individual, program, and organizational level. The Round Table participants were:

1. John Mohler, Family Member
2. Manuela Dalla Nora, VITA Community living Services
3. Lynne Hillman, Concurrent Disorders Support Services
4. Paul Quinn, Gerstein Centre

Some of the key challenges raised by Round Table members, with further input from participants included:

Finding the Pathways to Service and Staying on the Path

- Lack of understanding from people in the community
- Difficulty in finding answers and resources and to work across sectors
- Functioning as service and pathways to access are the exception rather than the rule (working on one case at a time and using relationship-based rather than systematic processes)
- Helping families to “find the door”; lack of case management and advocates
- How to make the connections with multiple service sectors that will last and stay with a client throughout their life-time journey, and when there are no family supports
- Broadly understanding who to engage

Establishing Partnerships

- Lack of understanding of the roles and services delivered within the different sectors and by hospital/institutional and community service providers
- Situations involving persons with a dual diagnosis are highly complicated and require connections to other networks in order to provide broader, deeper and better services
- Difficulty getting your partners in place

- Determining what agencies have capacity and agencies defining the limits of capacity – what is good enough?
- How does developmental service sector find out more about the justice system, how it works?
- Working across boundaries, knowing who to connect with, who to ask for
- Educating cross sectorally – and having people who are willing to partner – and to educate each other

Justice Involvement

- The challenge of how to connect when Dual Diagnosis client is in apprehended or in jail.
- Connection with/access to psychiatric assessment and medical care while in jail (need medication, psychiatrist to prescribe, etc.).
- Huge population in jails that are waiting for beds, with no where else to go, so another version of Alternative Level of Care (ALC) from the Justice system connection.
- Communication protocols when client is in jail or getting released – getting property, medications, follow-up as needed, etc.
- Understanding safety/risk issues – difficulty for service providers to determine best and safest plans when aggression or other justice issues arise – for the individual, community, staff, other residents.
- Managing individuals who enter the justice system and are acutely psychotic, but have no family support system, and there is no way to get any type of history.
- Limited partnerships between Justice and other care providers – and how to start to build those connections; coordination requires a commitment.
- Better planning for what to do with this population at the point of disconnection from the Justice system (coming out of forensic units, jail system, bail/diversion [providers are being asked for Surety, which is of concern as far as organizational liability]).
- The approach for justice-involved individuals is case-by-case; there is no system level response.
- Diversion services are limited.

Housing

- Lack of appropriate, flexible, and inclusive housing strategies and supports – we don't have access to really good supportive housing for level of care required in terms of support intensity.
- Accessing high support for someone who has been incarcerated and drug addicted.
- Finding supportive, transitional beds for individuals in crisis.
- The issue of people with a dual diagnosis sitting in jail waiting for bed – jail is not the appropriate place for them – there need to be safe beds, transitional supports, but also longer term solutions.

Service Capacity

- Lack of day programming once clients are released from hospital; understanding the roles in the way the system works – who takes responsibility when we don't have the required capacity at the level of intensity required: all need to contribute to build support around the person.
- Services are transitional – for many a longer term solution is essential (e.g., when transitioned out of hospital).
- Having more flexibility within our delivery to be responsive to individual needs, develop a support package with enough in place as far as intensity.

Cultural/Diversity Issues

- Cultural barriers for families new to Canada; lack of culturally appropriate services, including service in multiple languages.
- Neither the Mental Health(MH) nor Developmental Service (DS) sectors are addressing the needs of diverse populations well, so need to reach out to and engage with these communities.
- We have learned that the justice system has a higher representation of non-Caucasian individuals, so that pathway is 'open', which is a clear equity issue.

Transient/Homelessness

- Difficulty in coordinating and effectively supporting a transient (and homeless) population, and ensuring continuity.

Health Care

- Access to primary health care with expertise, willingness to serve persons with a Dual Diagnosis, and collaborate with family and providers as needed.
- Ensuring the people with a dual diagnosis get a good medical assessment.
- Ensuring there is understanding of the issues at play (Safety, MH/bio-psychosocial assessment) and the need for collaborative approaches to assessment, treatment and delivery.

Adequate Assessments

- Issue of capacity (psychiatrists) – severely restricts access to a clear diagnosis. If individuals with a dual diagnosis could get a good assessment up front, and more quickly, the pathways could be developed to appropriate supports before the long journey.
- Understanding complex relationships between disability and Mental Health issue; identifying the problem before it becomes a crisis.
- Needing to equip the family physician with knowledge because they are typically the first point of contact; families could be teachers – collaborate with physicians and use retiring GPs as mentors.

- Building understanding and making bridges between the cause and the presenting behavioural challenge at hand (which may create risk for person, family, caregivers); need quick response including a bio-psychosocial approach or several pieces of it – the need to roll all of those things out, and quickly.

Family Member Support

- Support for families...crisis occurs when family is no longer able to support the person.
- Worries of family members who are aging, or have heart/stress issues and feel they have to hang on forever to care for their child/family member with a dual diagnosis.
- The “child” has to come home when all else fails, so many families are supporting individuals with complex issues who are not able to be supported by the DS and MH sectors, and they are the deferral caregiver, no matter how complex the needs and intensive the support requirements.
- How to support the families who are supporting someone with a dual diagnosis.
- Suggestion that in many situations we cannot do enough, and we need to define what we can and can't do, understanding that we are doing what is possible, within the resources available, and given the complexities, in the safest possible environment. At some point, acknowledging this will help to address the challenges that are often felt as caregivers not being able to provide ‘enough’ to support the person.

Identifying the Key challenges

The above discussion points were synthesized into 10 key challenges:

1. To build the capacity, especially with the new players, related to access to services/ supports determining and building on pathways that are already in place.
2. Prevention of entry into the justice system, especially when individuals are in need of treatment (e.g., experiencing acute psychosis).
3. Addressing burnout of caregivers, including families – especially when you are not seeing long-term stable solutions to sometimes complex situations and needs.
4. Access and outreach (address help seeking and pathways) to culturally diverse families and communities.
5. How to learn about other sectors (e.g., justice, health, primary care) by agencies and networks.
6. Now that we have transitional and crisis supports well developed and in place, how do we move to long-term solutions for complex situations.
7. How to support the totally unconnected person with no advocate.
8. How to engage primary care as a key element of the collaborative support approach and in knowledge capacity building in order to be able to respond effectively.
9. Increasing numbers of individuals with substance use, given substance use is a risk factor for justice system involvement for persons with a dual diagnosis.

10. Different capacity to assume risk across the sectors (understanding risk, assessing risk, offering surety).

Collaborating on Outcomes and Strategies

Individual work groups (at each of 10 tables) were assigned a “challenge” and asked to:

1. Gain clearer perspective on the challenge by discussing it and making it come to life given the different perspectives at the table.
2. Determine existing good practices and ideas that could address the challenge.
3. Establish key desired outcomes.
4. Brainstorm collaborative strategies to address the challenge and achieve desired outcomes.
5. Identify potential collaborators – who does this matter to?

Please see Appendix D for the completed worksheets from the majority of the small group sessions.

What Matters Most

In order to establish priority goals – to begin working on those challenges that matter most – the challenges from the morning were re-worded as “goals” and forum participants were asked to identify the priority challenges, keeping in mind what is most important, as well as what is likely to have a successful outcome/be ‘doable’. Each participant was given three “dots” in order to vote on their “top three” challenges. Following is the list of Priority Goals, in order by number of votes:

1. Establish a single point of contact for anything to do with Dual Diagnosis – across sectors, and for all stakeholders (individuals, families, providers). **(33 votes)**
2. Work together regionally and across/between ministries to jointly develop the strategies, pathways, and structures needed to ensure adequate resources and to operationalize coordinated delivery on the ground (with particular focus on specific interest groups such as ALC and ER Crisis, and high priority sub-populations). **(29 votes)**
3. Increased education and awareness of Dual Diagnosis services and available resources for front line workers and “up the line”, including organizational management and funders. **(24 votes)**
4. Primary care engagement and collaboration: Close the gap between Developmental, Mental Health and Primary Care Services to ensure education, participation as network partners, leadership, capacity building, collaborate with LHINs to bring about engagement (consider role of Community Health Centres (CHCs), Inner City Health Association). **(21 votes)**

5. Develop a cross-sectoral strategy/initiative – ensuring responsive and effective frontline solutions at the individual level (including strategies to connect with individuals in need (e.g., peers). **(11 votes)**
6. Increased capacity and mandate to deliver culturally competent services and promote awareness (outreach and education) (go to families with DD kids and in schools before individuals fall off the edge at age 18-21). **(5 votes)**
7. Operationalize policy so there is frontline education and communication in all sectors (the front doors), money invested into new service (cost sharing strategy) – justice, health, MCS. **(4 votes)**
8. Better support/involvement/resources for caregivers (all supporters) with connections/training across sectors (broaden community of support and connection for caregivers) inclusive circles of care. **(3 votes)**
9. Education for all sectors and research and best practice guidelines/adapted approaches for DD population with substance use/abuse issues (including issues of access to programs currently offered through the Addictions Service Providers). **(2 votes)**

Each table was asked to first reword the goal and to then identify:

- Actions steps (three things we need to do to achieve the goal – collaborative action steps focused on practical, concrete ideas to ensure success/make it happen)
- Who needs to be involved (i.e., individuals, organizations, stakeholder groups)
- When and how to get feedback on outcomes
- How/where (e.g., project focus, table)

Collaborative Action Planning

Goal #1:

Establish a single point of contact for anything to do with Dual Diagnosis - across sectors, and for all stakeholders (individuals, families, providers).

(Note: this goal was assigned to two separate work groups with inputs recorded separately as Table A and B below)

Table A

Reworded Goal:

To develop a single or coordinated point of access for people affected by Dual Diagnosis.

Action Steps:

1. Look at existing mechanisms, and research prevalence rates to form a compelling argument to get funding (CAMH, LHIN/MOHLTC, CNSC, MCSS Regional, U of T) (one year for funding proposal). Present proposal for funding.
2. Develop a framework by looking at options already in existence (i.e., add on to existing 2-1-1 line, to include mental health, how to connect with DS Application Entity under development) (18 to 24 months).
3. Develop integrated response through phone line, website, advertisements; implement (one year).
4. Operationalize (four to five years).

Involve	Champions	How/Where (existing table, project focus)
<p>Action Step 2:</p> <ul style="list-style-type: none"> • MOHLTC • MCSS • MCYS • MTCU • MAG • Ministry of Community Safety & Correctional Services (MCSCS) <p>Action Steps 2 & 3:</p> <ul style="list-style-type: none"> • Families • Agencies (e.g., VITA) • CAMH • Reconnect • Individuals • Family groups • CAS • LHINs • Griffin Centre • Doctors • Police • Crisis Workers (Gerstein) • Cultural Services, FLS, LGBT/T20 	<ul style="list-style-type: none"> • CNSCs • Ministries • Advocacy group • Doctors • Griffin Centre • Agency EDs 	<ul style="list-style-type: none"> • MCSCS • MOHLTC • MCSS • Self Advocate • VITA • CAMH • TNSC

Table B

Reworded Goal:

Establish one single point of contact for all dual diagnosis resources to improve access and ensure continuity of service building upon existing structures. (i.e., require revised mandate for Provincial Community Networks of Specialized Care to ensure continuity of service), and fund system navigators.

Action steps:

1. Ask for support and recruit champions for the process; get everyone at the table. Engage in research, consulting, and develop proposal and process.
2. Develop a joint proposal looking at financial systemic justification for revised mandate (better outcomes for clients), as well as proposal for at least one system navigator per network to bring together the right sectors. Bring everyone to the table to get buy in. The Network leads agree to the proposal and buy-in, and then champion it along with the Ministry representatives. Proposal to be supported through TC LHIN, TCNSC and HSJCC, so cross-sectoral/network ownership and collaborative development and pitch.
3. Convince the three Ministries (MCSS, LHIN/Health and Justice) to invest in the revised/expanded Information and Referral mandate for the networks provincially.

Involve in pitching the proposal	Champions
<ul style="list-style-type: none"> • John Flannery • Laurie Dart • Susan Morris • Manuella Dalla Nora • Sandra Bricker • Network leads • Parent groups <p>Other involvement:</p> <ul style="list-style-type: none"> • GTA LHINs • Mental Health Diversion • MCSCS: deputy Minister • MCSS; Deputy Minister 	<ul style="list-style-type: none"> • Networks of Specialized Care (they have connections to other sectors) • Link to Application Entities

Goal #2:

Work together regionally and inter-ministerially to jointly develop the strategies, pathways, and structures needed to ensure adequate resources and to operationalize coordinated delivery on the ground (with particular focus on specific interest groups such as ALC and ER Crisis, and high priority sub populations).

Reworded goal:

Toronto LHIN, TNSC and Regional office work together on strategies to address areas where there is an alignment of priorities, e.g., pathways and strategies to address Alternate Level of Care – ALC (hospitals, community specialized beds, jail), prevention of ER, use wait times (for specialized services in hospital and community).

Action Steps:

1. Toronto LHIN, CNSC, Regional office, Toronto HSJCC define the aligned areas and realistic outcomes for year 1 and 2.

Involve:

- Linda Montgomery, Toronto HSJCC

- TC LHIN
 - John Flannery – Surrey Place Centre
 - Sandra Bricker – TNSC
 - Laurie Dart, Griffin
 - Kerry Ann Markle, MCSS
 - Ministry of Community Safety & Correction Services (MCSCS)
 - DSTO (Developmental Services Toronto)
2. Collect evidence – based on definitions – use existing information sources to further understand and describe the alignments, the issues, the current pathways, the actual individuals and the gaps in community service leading to ‘heavy use’ of most intrusive/costly services. Gather data from existing groups and existing databases to show the ministries why they should be concerned, given that there is a high service use population with complex needs, many of whom are persons with a dual diagnosis, using the most costly services which all funders are concerned about. See what the trends are in what resources are being used. The data should come from all sectors to see what the demand and the impact is. Examples:
- Repeat and long-term users – people crossing all sectors
 - Alternate Levels of Care (ALC) (existing hospital data regarding primary/secondary diagnosis of ALC patients, Service Resolution referral and outcome data)
 - Emergency Room (ER) (review research study results to make case regarding need for non-crisis/ER responses)
 - Justice issue (existing hospital data and Justice Case management data, information from Forensic Committee regarding blocked beds, individuals currently in jail, or held in detention due to lack of housing/support resources)
3. From this evidence, identify pathways that are working, the gaps, and how the gaps could be filled through increased resources and more efficient and effective use of existing resources (e.g. through collaboration); get all the Ministries pulling together to create pathways to community-based collaborative services. Identify a better way to respond to the people and the resources that are being used; determine how to engage people.

Involve	Champions	How/Where (existing table, project focus)
<ul style="list-style-type: none"> • LHIN • CNSC • Hospital providers 	<ul style="list-style-type: none"> • Laurie Dart • Susan Morris • Saul Goodman • Yona Lunsky • Linda Montgomery • Don Jail Health Practitioners 	<ul style="list-style-type: none"> • Research Committee of CNSC? • HSJCC • TC LHIN Advisory Tables

Goal #3:

Increased education and awareness of Dual Diagnosis services and available resources for front line workers and “up the line”, including management and funders.

Reworded goal:

Through education, cross-sectoral front-line staff, management, and funders have an increased understanding and awareness of Dual Diagnosis and the services and resources that are available.

Action Steps:

1. Research what education/curriculum is available and being delivered, and build buy in.
 - a. Identify who will do this research
 - b. What is available – keep it current; what exists in various providers, Boards of Education, academic partners, TNSC, multi-modality – e-learning
 - c. Get support/feedback from doctors, nurses, education practitioners – commenting on what they want given the information/research we present
 - d. Connect who is doing research already and pull the work together; integrate the curriculum
 - e. Influence decision makers to have this within curriculum – adding to the body of knowledge that already exists.
2. Develop and approve curriculum
 - a. Develop and approve the curriculum that could be delivered by anybody at any time (train the trainer): same sectors
 - determine where it will be housed
 - who are stakeholders that are involved
 - get buy in internally (e.g., doctors, HSJCC, NADD, CNSC)
 - develop focus groups
 - get feedback and use this when developing curriculum
3. Implementation and delivery of curriculum
 - a. Implementation and delivery of this curriculum; make sure information is updated as need be; various organizations committed to following through and seeing it through
 - use pre- and post-questionnaire to get feedback, as well as ongoing evaluation
 - train the trainer model
 - consistent and current
 - transfer of knowledge (e.g., Griffin and George Brown certificate program)
 - revisit and add to expand existing models (e.g., Training in Partnership, ESR) that are specific to dual diagnosis

Outcomes: people are learning about DD, signs of need for further assessment/exploration, how to connect with the systems

Involve	Champions	How/Where (existing table, project focus)
<ul style="list-style-type: none"> • U of T, Department of Psychiatry • Boards of Education • Nursing schools • Police College • Be inclusive of consumers and families • George Brown College? 	<p>Involving/getting feedback from stakeholders to find out what they want; what information they are missing – that what they develop is in keeping with what they want:</p> <ul style="list-style-type: none"> • MHJN • Police Sector Services • CAMH • Be inclusive – include consumers and families (Concerned Parents as educators) 	<ul style="list-style-type: none"> • Collaborative – all • TSNC • National Association of Dual diagnosis (NADD) • CNSC Tri-Region • Central Region Network of Specialized Care already doing work • DSTO network • LHIN • HSJCC • CHCs

Collaborating on What Matters – Moving Ahead Together

Jim Johnston, a family member, encouraged everyone to come together and collaborate as it is “critical to the quality of life of our children”. He stated that there is hope that “someone will actually roll up their sleeves and do something about it” and he hopes that this time people will say that they are willing to help start this.

Participants suggested that we need to loop back to family members and to this group. The consultant reiterated that accountability is really important and that this is an action-taking process and commitment is needed from each one of us – “it’s easy to talk but we need to take action and we have a commitment to report back to Jim. You need to promise that you will say ‘yes, it’s important and I’m willing to do something about it.’”.

Afterword

Despite the continuing challenges experienced by persons with a dual diagnosis, their family members, and those who are engaged to support them, it needs to be acknowledged that significant commitment has been made and outcomes have been achieved over the past five years, through exceptional collaboration. Canadians are well ahead of the curve in network-based collaboration – and the cross-sectoral work in Toronto in support of persons with a Dual Diagnosis has been at the leading edge.

The Griffin Community Support Network, and several related interagency collaboration projects, the Dual Diagnosis Implementation Committee, the Toronto Human Services and Justice Coordinating Committee, the Community Network of Specialized Care, and most recently the Concurrent Disorders Network, are leading examples of people and sectors interconnecting,

sharing knowledge, creating understanding, and building relationships in support of those in need.

As these networks mature, new partners are identified who need to be ‘brought to the table’ to enrich the capacity of providers to support people and their families. But we know that there are still many individuals who are not being adequately served, and that their needs are complex. We know that some of these individuals have been marginalized, either in families who have not been able to access critical services and supports (in particular those who, for a number of reasons, including their membership in diverse communities, whether ethno-culturally or socioeconomically).

We need to continue to widen our span of participation and, in spite of the lack of service capacity we are all aware of as providers, we need to work to engage individuals who may be ‘hidden’ in the forensic system, on the street, in long-term care facilities, in regional psychiatric facilities, and within families who are struggling to support and care for their sons, daughters, sisters, or brothers.

We are connecting to make a difference, certainly, but we must keep building, thinking about who are the most vulnerable persons, and working to engage partners in order to effectively respond to their needs.

Each participant in the aforementioned networks, and at the Dual Diagnosis Forum 2010, needs to continue with commitment, passion, and a focus on action – to make a difference. We need to consider and act for those who may currently be without advocates, or indeed for those whose family members are stressed, struggling, and in need of a collaborative response.

Together we need to keep our eyes on the mission of making a difference in the health and quality of life of persons with a Dual Diagnosis. This means that we have to think of, and act collectively, in support of the individuals at risk. At the same time, we need to keep our sights on each of the systems that have a clear responsibility. We need to continue to press for collaborative action and delivery on the commitment of our funders.

Summary

The Dual Diagnosis – Collaborating for Solutions Forum was a collective effort from different sectors in terms of planning and working together around a specific population whose needs cross many sectors. It was important to establish a planning group that had representation from the different perspectives and mandates. This group was able to bring together key contacts to be part of the forum. Although there are differences in focus, there are areas where cross-sector work can occur.

The Networks of Specialized Care have the mandate to enhance services to adults with a developmental disability and mental health needs and/or challenging behaviour. This is to be done by linking and building relationships with different sectors as well as increasing community capacity through education and training.

The LHINs have priorities of Mental Health and Addictions, ER wait times, ALC designation and Diabetes. The dually-diagnosed population intersects with all the above priorities.

In terms of the priorities that were generated at the Forum, there are parallels in the current work of both the LHIN and the TNSC. It is important to note that there are projects underway which can address what was identified as needing to occur.

In the Developmental Service system there is a transformation occurring which will have a single point of access to developmental services for adults, called Application Entities. It is not clear at this point where the CNSCs will fit; however, one can assume that people with a dual diagnosis will be included in this system. In the LHIN current system coordination initiatives include coordinated access to Mental Health and Addictions Supportive Housing and coordinated access to Mental Health intensive case management and Assertive Community Treatment Teams, and Resource Matching and Referral.

The statistics provided show that people with a dual diagnosis are part of those who are in the ALC group, are repeat visitors to the emergency departments and are more likely to have health issues as compared to the general population.

The top three priority goals were:

1. Establishing a single or coordinated point of contact for dual diagnosis
2. Jointly develop pathways, strategies and structures needed to ensure adequate resources and to operationalize coordination of delivery on the ground. *Linkages between the TNSC, MCSS Regional Office and the TCLHIN to look at pathways and priorities – where they align and can intersect across the sectors.*
3. Increased education of dual diagnosis services and resources. *The mandate of the networks includes education and training. Toronto Network of Specialized Care is part of the Central Region (MCSS) and has a role in education and training in the area of dual diagnosis. There are two curricula currently available through the network: one directed for case managers and the other for managers/supervisors.*

Along with these there were other goals which people in attendance felt were important. Some of these may be achievable in the short term as well. See Appendix F

Next Steps

1. Examine the priority goals and develop a work plan addressing how they fit within the mandates and priorities of the various sectors.
2. Engage policy makers in a dialogue on how to move forward.
3. Hold a meeting with Surrey Place, CAMH, TNSC and TCLHIN representatives. regarding emergency room use and health care needs.
4. Work on determining how the emerging access structures intersect.

References

- American Association for Mental Retardation (2002). *Mental Retardation: Definition, Classifications and Systems of Supports Manual*. (Currently the American Association on Intellectual and Developmental Disabilities (AAIDD).)
- Balogh, R., Bretherton, K., Whibley, S., Berney, T., Graham, S., & Richold, P., et al. (2001). Sexual abuse in children and adolescents with intellectual disability. *Journal of Intellectual Disability Research*, 45(3), 194-201.
- Balogh, R., Ouellette-Kuntz, H., Colantonio, A., Bourne, L. (2007, unpublished manuscript). *Organising Health Care Services for Persons with an Intellectual Disability: A Systematic Review*.
- Bouras, N. (1999). *Psychiatric and behavioural disorders in development disabilities and mental retardation*. Cambridge: Cambridge University Press. Bryson, S. E., Bradley, E. A., Thompson, A., Wainwright, A. (2007). Prevalence of autism among adolescents with intellectual disabilities.
- Bouras, N., Holt, G., Day, K. and Dosen, A. (1999) *Mental health in mental retardation: the abc for mental health, primary care and other professionals*, London: World Psychiatric Association, Section on Mental Retardation. Full text available at: <http://www.wpanet.org/sectorial/mhinretard1.html>.
- Brown H K; Ouellette-Kuntz H; Bielska I; Elliott D. (2009) Choosing a measure of support need: implications for research and policy. *Journal of intellectual disability research: JIDR* 2009; 53(11):949-54.
- Burge, P. (2009). *Assertive Community Treatment Teams and Adults with Intellectual Disabilities*. *Journal on Developmental Disabilities*.
- Griffiths, D.M., Stavrakaki, C., & Summers, J. (eds.) (2002). *Dual Diagnosis: An introduction to the mental health needs of persons with developmental disabilities*. Habilitative Mental Health Resource Network. Ontario.
- Central Region Network of Specialized Care (2007). *Developmental Disabilities, Mental Health Needs, and Challenging Behaviours: A summary of the research on prevalence, characteristics, and intervention*. 2007 Research Think Tank
- Cooper, S., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *British Journal of Psychiatry*, 190(1), 27-35.
- Deb, S., Matthews, T., Holt, G., & Bouras, N. (2001). *Practice guidelines for assessment and diagnosis of mental health problems in adults with intellectual disability*. Brighton: Pavilion; 2001.

- Doody, G. A., Thomson, L. D. G., Miller, P., & Johnstone, E. C. (2000). Predictors of admission to a high-security hospital of people with intellectual disability with and without schizophrenia. *Journal of Intellectual Disability Research. Special Issue: Mental health and intellectual disability: VI, 44(2)*, 130-137. *Developmental Disabilities, Mental Health Needs, and Challenging Behaviours: Page 51 of 69* A summary of the research on prevalence, characteristics, and intervention
- Dykens, E. M., Hodapp, R. M., & Finucane, B. M. (2000). *Genetics and mental retardation syndromes: A new look at behavior and interventions*. Baltimore, MD, US: Paul H Brookes Publishing.
- Emerson, E., & Emerson, C. (1987). Barriers to the effective implementation of habilitative behavioral programs in an institutional setting. *Mental Retardation, 25(2)*, 101-106.
- Emerson, E., & Hatton, C. (2007). *The Mental Health of Children and Adolescents with Learning Disabilities in Britain*. Institute for Health Research: Lancaster University.
- Espie, C. A., Watkins, J., Curtice, L., Espie, A., Duncan, R., & Ryan, J. A., et al. (2003). Psychopathology in people with epilepsy and intellectual disability; an investigation of potential explanatory variables. *Journal of Neurology, Neurosurgery & Psychiatry, 74(11)*, 1485-1492.
- Evenhuis, H. M., Theunissen, M., Denkers, I., Verschuure, H., & Kemme, H. (2001). Prevalence of visual and hearing impairment in a Dutch institutionalized population with intellectual disability. *Journal of Intellectual Disability Research, 45(5)*, 457-464.
- Glaser, W., & Florio, D. (2004). Beyond specialist programmes: A study of the needs of offenders with intellectual disability requiring psychiatric attention. *Journal of Intellectual Disability Research, 48(6)*, 59-602.
- Glaser, W., & Deane, K. (1999). Normalisation in an abnormal world: A study of prisoners with an intellectual disability. *International Journal of Offender Therapy and Comparative Criminology, 43(3)*, 338-356.
- Hamilton, D., Sutherland, G., & Iacono, T. (2005). Further examination of relationships between life events and psychiatric symptoms in adults with intellectual disability. *Journal of Intellectual Disability Research, 49(11)*, 839-844.
- Hayes, S. (1991). Sex offenders. *Australia & New Zealand Journal of Developmental Disabilities. Special Issue: Challenging behaviour, 17(2)*, 221-227.
- Hayes, S., Shackell, P., & Mottram, P. (2007). The Prevalence of Intellectual Disability in a Major UK Prison. *British Journal of Learning Disabilities, 35*, 162-167
- Hersen, M., & Bellack, A.S (eds) (1988). *Dictionary of Behavioural Assessment Techniques*. Pergamon Press: Oxford.

- Hurley, A. D., Folstein, M., & Lam, N. (2003). Patients with and without intellectual disability seeking outpatient psychiatric services: Diagnoses and prescribing pattern. *Journal of Intellectual Disability Research*, 47(1), 39-50.
- Johnston, J (2009). Presentation to the Select Committee on Mental Health and Addictions, on behalf of NADD Ontario.
- Johnston, J. & Morris, S. (2009). Dual Diagnosis: System design for individuals with developmental disabilities and mental health needs. Select Committee on Mental and Addictions.
- Jones, J. (2007). Persons with Intellectual Disabilities in the Criminal Justice System: Review of issues. *International Journal of offender therapy and Comparative Criminology*, 51
- Kastner, T., Walsh, K. K., & Fraser, M. (2001). Undiagnosed medical conditions and medication side effects presenting as behavioral/psychiatric problems in people with mental retardation. *Mental Health Aspects of Developmental Disabilities*, 4(3), 101-107.
- Kerr, M. (2006). Improving the general health of people with intellectual disabilities. *Directions in Psychiatry*, 26(4), 235-240.
- Loucks, N. (2009). The prevalence and associated needs of offenders with learning difficulties and learning disabilities. Briefing Paper, No One Knows, Prison Reform Trust.
- Lowe, C., & Temple, V. (2002). Identifying hearing loss in adults with developmental disabilities. *Journal of Speech-Language Pathology and Audiology*, 26(1), 20-26.
- Lunsky, Y., Bradley, E., Durbin, J., Koegl, C., Canrinus, M., & Goering, P. (2003). Dual diagnosis in provincial psychiatric hospitals: A population-based study. Toronto, ON: Centre for Addiction and Mental Health. Received from: http://www.camh.net/Care_Treatment/Resources_for_Professionals/
- Lunsky, Y., Gracey, C., Koegl, C., Bradley, E., Durbin, J., & Raina, P. (2010). The clinical profile and service needs of psychiatric inpatients with intellectual disabilities and forensic involvement. *Psychology, Crime & Law*, 1-15
- McGillivray, J. A., & Moore, M. R. (2001). Substance use by offenders with mild intellectual disability. *Journal of Intellectual & Developmental Disability*, 26(4), 297- 310.
- Morris, S. (2009). Dual Diagnosis and the Justice System: Where they Intersect. PowerPoint Presentation (unpublished document).
- Pack, R. P., Wallander, J. L., & Browne, D. (1998). Health risk behaviors of African American adolescents with mild mental retardation: Prevalence depends on measurement method. *American Journal on Mental Retardation*, 102(4), 409-420.

- Raina, P., Khodaverdian, A., Jones, J., & Lunsky, Y. (2009). A Comparison of Adults in Crisis with a Developmental Disability With and Without a History of Legal Trouble. Centre for Addiction and Mental Health, Dual Diagnosis Research Program(Poster Session at OADD and NADD).
- Raina, P. & Lunsky, Y. (2010). A comparison study of adults with intellectual disability and psychiatric disorder with and without forensic involvement. *Research in Developmental Disabilities*, 31 218–223
- Ryan, R., & Sunada, K. (1997). Medical evaluation of persons with mental retardation referred for psychiatric assessment. *General Hospital Psychiatry*, 19(4), 274-280.
- Simpson, M. K., & Hogg, J. (2001). Patterns of offending among people with intellectual disability: A systematic review. Part II. Predisposing factors. *Journal of Intellectual Disability Research*, 45, 397–406.
- Sondenaa, E., Rasmussen, K., & Nottestad, J.A. (2008). Forensic Issues in Intellectual Disability. *Current Opinion in Psychiatry*, 21:449–453
- Wheeler, j., Holland, A., Bambrick, M., Lindsay, Wl, Carson, D., Steptoe, L., Johnston, S., Taylor, J., Middleton, C., Price, K., O'Brien, G. (2010)Community services and people with intellectual disabilities who engage in anti-social or offending behaviour: referral rates, characteristics, and care pathways. *Journal of Forensic Psychiatry & Psychology*. March. available at <http://www.informaworld.com/smpp/title~content=t714592861>
- Yu, D., & Atkinson, L. (1993). Developmental disability with and without psychiatric involvement: Prevalence estimates for Ontario. *Journal on Developmental Disabilities*, 2(1), 92-99. *Developmental Disabilities, Mental Health Needs, and Challenging Behaviours*: Page 68 of 69 A summary of the research on prevalence, characteristics, and intervention

Appendix A: Forum Agenda

Agenda		
8:30	<i>Coffee and Gathering</i>	
9:00	Collaborating For Solutions <i>Opening Remarks</i>	Karen Meehan, MCSS Barbara Everett, TC LHIN Board
9:15	Video Clip	Jim Johnston, Family Member Jenny Carver
9:30	Context For The Day – Why Collaborating Matters!	Jenny Carver
9:45	Articulate The Challenges To Collaboration In A Complex, Sectored World <i>Round Table – Experiences & Perspectives</i>	Jenny Carver (Facilitator) <u>Round Table:</u> John Mohler, Family Member Manuela Dalla Nora, VITA Community Living Services Lynne Hillman, Concurrent Disorders Network Paul Quinn, Gerstein Centre
11:00	<i>Break</i>	
11:15	Identify Key Challenges <i>Assign The Task</i>	Jenny Carver
11:30	Collaborate On Outcomes & Strategies <i>Small Work Groups</i>	Small Work Groups
12:30	<i>Lunch</i> <i>12:45-1:15 – Reachout Presentation</i>	
1:30	Collaborate On Outcomes & Strategies <i>Report Back</i>	Small Work Groups
2:00	What Matters Most? <i>Establish Priority Goals</i>	Jenny Carver Large Group
2:30	Collaborative Action Planning <i>Small Work Groups & Report Back</i>	Small Work Groups
3:30	Develop Integrated Action Plans	Jenny Carver Large Group
3:45	Collaborating On What Matters – Moving Ahead Together!	Jim Johnston, Family Member Jenny Carver

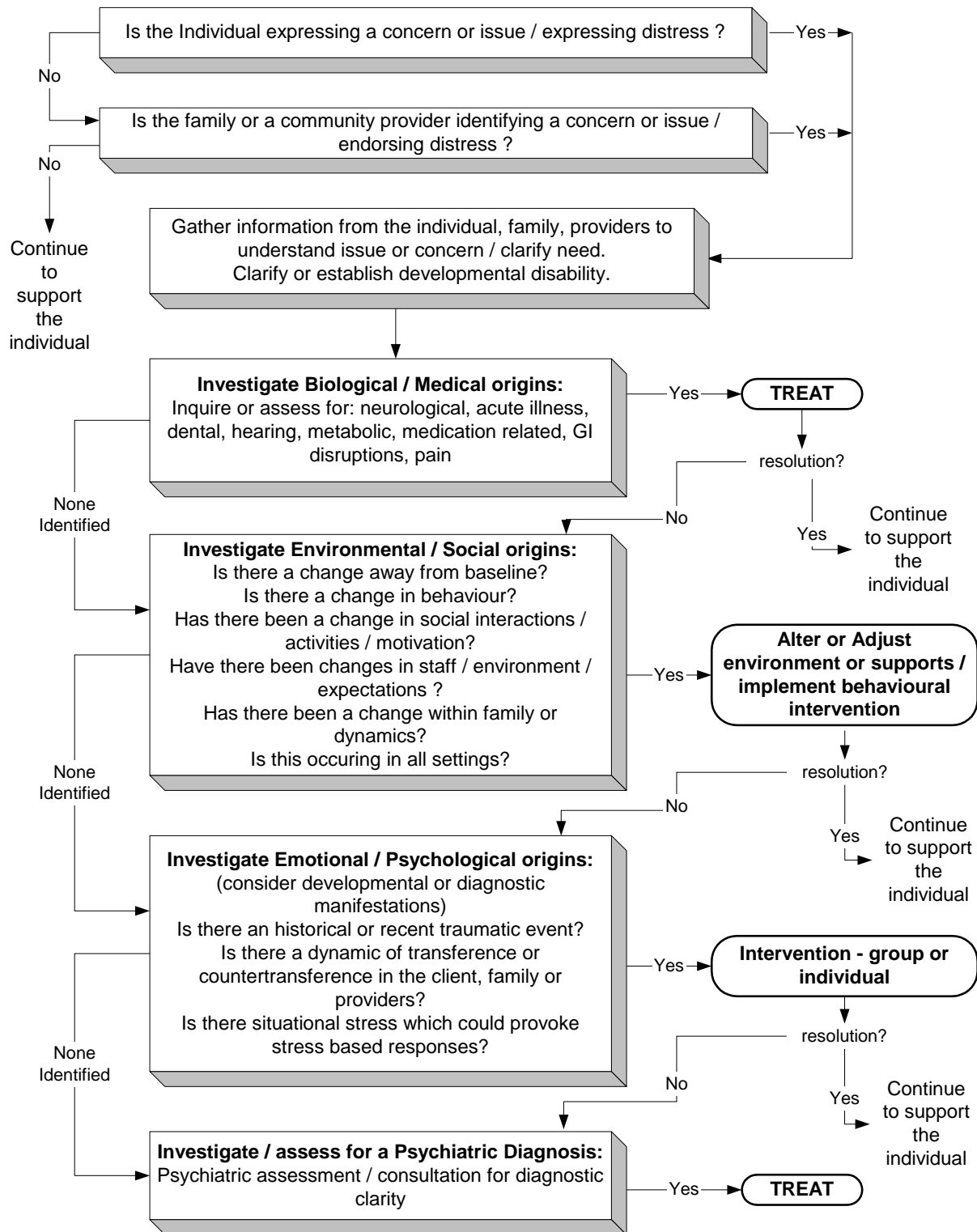
Appendix B: Participant List

Organization	Participant
Aboriginal Legal Services of Toronto	Clark, Charles
Aboriginal Legal Services of Toronto (ALSTC)	Pagano, Colette
Aboriginal Mental Health and Addictions	Trajlovic, Kelly
Canadian Mental Health Association	Davidek, Martin
Central Toronto Youth Services	Sliwinski, Deborah
Central West LHIN	Lewis, Janesca
Centre for Addiction and Mental Health	Cybulskie, Dinah
Centre for Addiction and Mental Health	Gittins, Sheila
Centre for Addiction and Mental Health	Morris, Susan
Christian Horizons	Uzukwu, Emmanuel
CMHA Peel	Truong, Francisco
Concurrent Disorders Support Services	Hillman, Lynne
Corbrook – Awakening Abilities	Soni, Deepak
COTA Health	Klassen, Colleen
COTA Health	Facey, Junie
DSTO (Developmental Services Toronto)	Altosaar, Jennifer
Family Member	Johnson, Jim
Geneva Centre for Autism	Irish, Debbie
Griffin Centre	Cappelletti, Gabriella
Griffin Centre	Dart, Laurie
Griffin Centre	Eisenberg, Beth
Heep Chi Association	Kwan, Renee
Human Services and Justice Coordinating Committee	Montgomery, Linda
JVS Toronto	Piotrowski, Jacqueline
Kerry's Place Autism Services	Conant, Stephanie
Kerry's Place Autism Services	Persaud, Joe
Ministry of Community and Social Services	Damani, Dipal
Ministry of Community and Social Services	Majumder, Reshmi
Ministry of Community and Social Services	Markle, Kerry Ann
Ministry of Community and Social Services	Meehan, Karen
Ministry of Community and Social Services	Shaw, Jill

Organization	Participant
Ministry of Community Safety & Correctional Services	Innocent, Myriam
Ministry of Community Safety & Correctional Services	Miller, Crystal
Ministry of Health and Long Term Care	Lang, Carol
Muki Baum Treatment Centres	Anderson, Kevin
Muki Baum Treatment Centres	Farrugia, Cheryl
Operation Springboard	Conrad, Liz
Operation Springboard	Grillo, Toni
Probation & Parole Officer	Wallace, Joy
Reachout	Hunt, Rainbow
Reconnect Mental Health Services	Badsha, Mohamed
Reena	Anbar, Michelle
Reena	Szabo, Ann
Reena	Zalev, Tamara
Salvation Army	Dickinson, Joanne
Salvation Army	Lawson, Cory
Sherbourne Health Centre	Wang, Mufan
Sistering	Sison, Stacey
Surrey Place Centre	Bissell, Margaret
Surrey Place Centre	Bricker, Sandra
Surrey Place Centre	Farber, Karyn
Surrey Place Centre	Flannery, John
Surrey Place Centre	Hewitt, Terri
Surrey Place Centre	White, Karen
The Bob Rumball Centre for the Deaf	Switzer, Tracey
The Four Villages CHC	Sharpe, Sally
The Gerstein Centre	Quinn, Paul
Toronto Central LHIN	Everett, Barbara
Toronto Central LHIN	Lucier, Lori
Toronto Central LHIN	Ambtman, Vanessa
Vita	Dalla Nora, Manuela
Woodgreen	Welsh, Mary Anne
xL Canada	Mohler, John

Appendix C: Dual Diagnosis Decision Tree

Dual Diagnosis Decision Tree



Adopted from Bradley & Summers, 1999
in Dual Diagnosis: NADD 2002

Appendix D: Morning Work Group Worksheets

Challenge # 1:

To build the capacity, especially of the new players, about how to access what they need and what pathways are already in place.

Perspective on the Challenge

- Define new players: staff, family, new sectors; anyone who needs support with access from the organization to the individual
- Communication challenge
- Senior staff mentoring new staff
- Information available about pathways, but where; overwhelming amounts of information – someone to direct to the most important
- Also do justice to address systemic capacity:
 - Define capacity
 - Lack of resources (i.e., housing)
 - Information
 - How do individuals get the information they need
 - How to develop a road map
 - Agencies and families see it differently
 - Understanding regarding inter-ministerial – how does any role work with other roles (i.e., hospital – Dual Diagnosis – tug between sectors) – look to collaborative approach

Good Practices and Ideas

1. CAMH Pathways Website

- may need more marketing
- book form for families

2. Networks of Specialized Care

- Education mandate – building capacity; specific focus on families
- Revised mandate for networks to expand capacity to include others. One stop shopping, one point of access

3. DSTO

- DSTO.com website – links i.e. concerned parents information

4. MSJCC

- Province-wide – MOH funding mainly run by service providers down to local level generating solutions/complex situations

5. Individualized Teams

- Multi-sector: police/Mental Health worker/other supports
- Crisis planning – pro-active – registry so get to the right access point for your situation

6. New Idea

- Cross-sector/cross-agency secondment

Key Desired Outcomes

1. Excellent understanding at the Ministry level of other Ministries' and sectors' roles and responsibilities, translating down to the service level. Everyone "knows" what they should do, where they should go.
2. Access pathways are clear.
3. Service Ontario – one stop.
4. Connection and collaboration and continuity when moving from one agency/sector – no dropping the baton.
5. Clients and families and agencies would access information about existing services in a timely fashion.

Collaborative Strategies to Address the Challenge and Achieve Desired Outcomes

1. Leveraging Networks of Care (existing structure): i.e., example of existing best practice also HSJC – entail more information and better understanding of services in all sectors.
2. Having a service provider worker work with mental health/housing/health.
3. Continue to use existing websites to link together to access information (i.e., family blog to talk to each other).

Potential Collaborators: Who Does This Matter To?

1. Families/clients
2. Service providers in all related sectors: Housing/Justice/Health/Mental Health
3. Ministries
4. Politicians

Challenge # 2:

Prevention of entry into justice, especially when they are in need of treatment (e.g., psychotic)
(Note: The worksheet for this Challenge was not handed in, so no transcription is available.)

Challenge # 3:

Addressing burnout of caregivers, including families – especially when you are not seeing long-term stable solution.

Perspective on the Challenge

Defining caregivers:

- Different groups with different solutions and needs
 - Caregivers as paid staff members
 - Families
 - Caregivers who have kids at home, not at home
- Who of these caregivers need support
- Nurses are caregivers in jail, as well as correctional officers
 - Difference in roles (handing out food, necessities)
 - Recognizing that burnout is different for various groups
- Families concerned with safety first

Cause of Stress:

- Lack of resources (funding, collaboration, services)
- Long-term versus short-term care
- Overwhelming situations where individuals may not comply (transient)
- Lack of knowledge of different sectors
- Workers (nurses) can change their jobs, families can't

Collaboration:

- Agencies have limited capacity to connect with community (they attend meetings, etc.)
- Agencies have to do more with less
- Consent! Not always given or parents not knowing about consent
- Short-term solutions are burning individuals out

Good Practices and Ideas

1. Respite:
 - a. Stress leave for families
 - b. Job sharing for workers – secondments
 - c. Crisis respite – for workers
2. Buddy System
 - a. Professionally or with families
 - b. Parent groups, family groups
 - c. Debriefing for workers and families
3. Training for workers
 - a. Motivational speakers at work
 - b. Wellness activities
4. EAP
 - a. Helpful for workers and families
5. Crisis services
 - a. Equipping family members with numbers, contacts

Key Desired Outcomes

Goal: Identify and reduce burnout; minimize short-term crisis responses; increase long-term planning for solutions

1. NO BURNOUT!
2. Less health issues for caregivers
3. Less stress/strain on health system
4. Less mental health days
5. Higher quality of life for families, employees, clients
6. Permission to find the best way to service clientele. Flexibility to try different things that can be done for clients – expand thinking.

Collaborative Strategies to Address the Challenge and Achieve Desired Outcomes

- Connections through conferences like this across sectors and families
- Job shadowing to gain knowledge of different situations
- Leaders knowledge sharing
- Consumer engagement outreach to engage community groups
- Primary care connection for family

- Education through research, conferences, experiences
- Social responsibility to take care of community
- Stereotypes and pre-disposed feelings need to decrease
- Parent groups – part of planning getting self-advocates involved
- More funding and resources in community

Potential Collaborators: Who Does This Matter To?

1. Families
2. MOHLTC, MCSS, MCSCS, EDU
3. Community, cultural groups
4. Developmental Services agencies
5. Primary care providers
6. Universities and colleges

Challenge # 4:

Access and outreach (address help seeking and pathways) to culturally diverse families and communities.

Perspective on the Challenge

- Connecting to other culturally-friendly supports (i.e., connect to person’s own community, primary health caregiver, culturally-specific housing); how to build the bridges with ethno-specific neighbourhoods.
- Establishing new Family Health Team in Don Mills. Encouraging new Canadian families to ask for help. There is shame, and they don’t want people to know. Need education for families, education in schools, educate other organizations.
- There is not just the problem of communication – often they speak English, but there are other problems connecting.
- Language barriers of newcomers; need to figure out how to connect people with resources.
- Need staff understanding of cultural differences; how to assist family through the steps and understand their barriers – not just translation – need deeper understanding, interpretation, double-check translated documents.
- Consent from adults 18 and over, and coordinating supports can take a lot of time; “shotgun” connection. Need to deal with disability first – convince family and client to acknowledge issue before they can move on.
- Mainstream organizations don’t have specialty in working with diverse cultures; there are financial constraints (i.e., translators). Do we pull resources from one program (where a staff is from a specific culture) if client is in another program?

- Volunteers from specific cultural group could be part of a family circle of care – case manager worries about boundaries of volunteer. Volunteers may be experts, but we need to support them better.
- Agencies do much more than just act as an agency – and the family gets connected and then don't want to go to another agency.
- Ministry direction needs to be given “kick start” – agencies push organizations to further address this issue.
- Diagnosis from childhood – things have changed, need current assessments.
- Acknowledge capacity of family to cope, how they deal with the challenges.
- Medication – over-reliance, look at other ways/sometimes families won't accept medication.
- Education around building diversity on staff teams and therefore developing greater connections with specific communities.

Good Practices and Ideas

1. In-house translators have been beneficial even if need to come from other programs; need to understand other programs.
2. Broaden collaborations within sectors as well as other sectors; recognize it's a lot of work to build these partnerships.
3. Education/partnerships; connections to guidance counsellors in schools; community centre, family health teams, training.
4. Taking opportunities – individual client needs can lead to new partnerships.
5. Staff development – lunch and learns about different cultures.
6. How can we learn about what exists – marketing is good, but can cause over-capacity.
7. Provide services to a broad range of consumers incorporating partnerships.
8. Intentionality in awareness; flexibility built into funding requirement.

Key Desired Outcomes

1. Measurable outcomes
2. Individual's health overall is maintained
3. Navigating the system – families/individuals get what they need
4. Sectors are connected, seamless
5. Transfer of knowledge and sustainable relationships – partnerships based on organizations, not just individual relationships
6. Funding/Service Agreement need to hold us accountable – language in agreement about who needs to be served (this supposes people are being turned down)

Collaborative Strategies to Address the Challenge and Achieve Desired Outcomes

1. Education is key – healthcare providers, parole officers deliver off-site workshops or invite others in for site visits face-to-face.
2. Getting real feedback from families – what are their ideas of what an ideal service would look like, including having consumers at planning.
3. Asking how we can do things better, within organizations and through partnerships.
4. Building better relationships with school boards.
5. Accountability – governments should encourage and mandate organizations to demonstrate their cultural competency (i.e., Diversity Committees, ongoing training, hiring practices).

Potential Collaborators: Who Does This Matter To?

1. Community health centres, hospitals, family physician
2. Policy level – funding sources
3. Consumer groups
4. Boards of Education
5. Jails, Corrections
6. Boards of organizations – making them aware – have consumer reps
7. Toronto Police across the City
8. Child protection agencies

Challenge # 5:

How to learn about other sectors (e.g., justice, health, primary care) by agencies and networks.

Perspective on the Challenge

- Information doesn't get filtered down – direct
- What is the information? Who needs to have the information? How do you get the information to the people who need to know?
- Not knowing the resources/agencies – need to learn what's out there – easy access to tools
- Primary care audience – they have all the knowledge family thinks – but trained by family
- Not knowing how to get the information
- Battling through the system – so big navigating the system
- Retired, aging population
- Parent to parent connection; informal peer support groups – need funding for these groups

- Who is the audience – taking advantage of current networks, systems to systems linkages, connections, ways to connect with the different

Good Practices and Ideas

1. Approach medical schools, colleges of physicians, new generation of doctors; communication tools – making use of these, i.e., student placements, more training, longer term; get into curriculum.
2. Networking – clinical networking, discussion groups, face-to-face meetings, workshops, trainings.
3. Talking to partners – you already have, building those partnerships.
4. Educating the broader community.
5. Looking into what works outside of our centre, research other jurisdictions.

Key Desired Outcomes

1. Fewer people appearing in ERs in crisis – early intervention – look at being proactive not reactive.
2. People feel connected to supports, communities, agencies, knowing who to call, sustaining the systems, systemic sustainability.
3. Barrier-free access to services, possibly fewer ministries, one access point so individuals will not get caught between the systems.
4. Systems work together – systemic sustainability – knowing who to call.
5. Access to good diagnosis.
6. Funding for psychology.

Collaborative Strategies to Address the Challenge and Achieve Desired Outcomes

Systems Level

- Being proactive, education piece
- Giving people information/resources proactively not in crisis
- Make it simple
- Review past successes
- Being sensitive to people's needs
- Education for GP frontline
- Cross-sector networking
- Discipline support network through the colleges
- Application entities
- More coordination of the websites – links

Organizational

- Within the frontline organization
- Making things simple
- Review past successes
- Training opportunities for staff at all levels

Individual

- Make it simple
- What they need to know when they need to know it
- Case manager, APSW
- Knowing what to ask
- Have the crisis plan having contingency plans

Potential Collaborators: Who Does This Matter To?

- Client, family
- Primary caregivers, emergency rooms
- Funders – Ministries
- Prison discharge person, Social Workers, mental health nurse in jails, police community relations
- Agencies, social service agencies across sectors – developmental, mental health
- Educators, universities, school board, college level – service stream
- Education continuum – school, college, university
- Housing – due to eviction, vulnerability
- Educate – broader community, neighbours, etc., building partnerships.

Challenge # 6:

Now that we have transitional and crisis supports nicely in place, how do we move to long-term solutions for complex situations.

Perspective on the Challenge

- Understanding what transitional is and build on the assumption that they can become self-sufficient and function with less support (transitional may include programs, counsellors and services).
- Transition allows for the long-term solutions by identifying issues and needs.
- Family – understanding transitional, meeting criteria, length of time in transition – how to provide information/educate/access to resources.

- Dealing with clientele that does not deal well with change.
- Coping with the change – collaboration with agencies.

Good Practices and Ideas

1. Robust continuum of services – housing need is huge (mental health disabilities) – system issues/programs and resources/flexibility from funders (mandate).
2. Networking – value system, philosophy, accountability – continue to develop network’s structure in place to continue to do so and establishing a pathway bringing everyone together in a coordinated fashion with ongoing training.
3. Collaborative responses need to be opened more outside of specialist – increasing staff and liaison between agencies.
4. Restraint with learning practices – service resolution (sitting together holding each other accountable by formulized process) – aligned with agencies at the client level – thereby expanding relationship with agencies.

Key Desired Outcomes

1. Measuring success – no repeat clients, decreasing the length of time – longevity of tenure; working hard without the timeline to reach goals.
2. Lower lengths of stay in corrections/forensic beds.
3. Professionals: knowledge/tools, point of contact also same family.
4. Tools: crisis plans, assessment tools – diagnostic – they being used, common language.
5. Family – clear accessibility when needed by providing a plan – prior to the need – reducing stress/intervention “getting along”.

Collaborative Strategies to Address the Challenge and Achieve Desired Outcomes

1. Need more money/services of service providers as opposed to shifting dollars at the agency level.
2. Working across sectors: moving out to all agencies to address long-term, not transitional issues; responsibilities to be readdressed – seeing global pictures.
3. Funding for agencies.
4. Developing a plan when needed that is flexible and movable between services.
5. Conversations must happen: 1) Ministry; 2) Agency; 3) Community.
6. Intra-ministerial ongoing contact/communication – collaboration; engagement – regarding operational issues, thereby impacting frontline services in order to provide adequate/appropriate services.
7. Common language – reporting requirements must be established with the guideline – it is important to show outcomes.
8. Liaison – identification of individuals within agencies – training/presentation.

9. Influencing policy in relation to implementation of policies now/before moving forward.
10. Long-term solutions require money – we can no longer do more with less.
11. Strategies – such as shared funding.
12. Address waitlist – bed space in corrections/shelters – having a resource pool.
13. Creating a new service pathway to build resources for services.
14. Regional networks of specialized care system/service pathways: ALC/ER/remanded in jail.
15. Development of services in response to repeat users/crisis/shelters/beds/hospitals.

Potential Priorities: Who Does This Matter To?

1. Regionally – Network LHINs and Regional MCSS offices work together to develop the system and service pathways in relation to ALCs (hospitals, safe beds, transitional beds) and repeat community crisis service users, emergency room users, and those remanded in jail.
2. Inter-ministerial strategy to provide appropriate resources to achieve #1.

Challenge # 7:

How to support the totally unconnected person with no advocate.

(Note: The worksheet for this Challenge was not handed in so no transcription is available.)

Challenge # 8:

How to engage primary care in current initiative and in knowledge capacity building (primary care).

Perspective on the Challenge

- Need doctors in harm reduction
- When referrals are made – providers don't take referral agencies seriously
- Speaking to agency representative – rather than patient
- Getting proper diagnosis
- No history – doctors who provide initial diagnosis don't follow individual
- Waitlists
- Referrals from secondary sources don't include accurate history
- Self referral depends on cognitive/intellectual level
- Emergency situations where no relationship is established, don't look to proper sources for information
- Patients ability to “give consent”

- Some individuals coming for service have little history
- Biases formed based on past situations no longer relevant
- Conflicting diagnoses/multiple diagnoses
- MHI/developmentally disabled persons not taken as seriously
- Discrimination against people with mental health issue and developmental disability (stigma) still exists
- Getting medical information from justice system
- How to marry different needs, mandates and ministries

Good Practices and Ideas

1. Establishment of longer-term relationships; continuity of relationships.
2. Crisis services with comprehensive follow-up / referral.
3. Proactive communication with existing services.
4. Have a contact person – community nursing/healthcare.
5. Bringing all players together and develop a crisis plan – information sharing.
6. Help family advocate regarding physician care – work with family.

Key Desired Outcomes

1. Education and training.
2. Harm reduction model/outreach.
3. Team approach – collectively – to look at whole person; holistic.
4. Collaborate for community/area providers to educate.
5. Access to primary care physicians; equity in access.
6. Establish a network.

Collaborative Strategies to Address the Challenge and Achieve Desired Outcomes

1. Getting to know who is who and come together and mobilize for training, education.
2. Need a connection to physicians (LHINS?); want to reach existing and new doctors (Mental Health sub group):
 - a. ICHA (Inner City Health Associates – Vicky Stmikes); find out what they're doing and how to access
 - b. Directory or resource
 - c. Website /links
3. Education and training.
4. Approaching Ontario College of Physicians – access.

5. Managing relationships around crisis services proactively.
6. Expanding reach of already existing services.
7. Help families to build continuum of care.
8. Educate doctors – provide information.
9. Access to crisis supports – clear sense of who does what .

Potential Collaborators: Who Does This Matter To?

Challenge # 9:

Increasing numbers of individuals with substance use.

Perspective on the Challenge

- Development delay – less substance use
- Not really increasing
- Self medication
- Relevant to those with concurrent disorder

Good Practices and Ideas

1. MOHLTC early discharge planning.
2. COTA discharge planners with major mental illness.
3. Case Management – case by case basis – outreach to services.
4. Developmental Disabilities screening tool to initiate referral for assessment.

Key Desired Outcomes

1. Best Practice guidelines.
2. Research:
 - a. Primary focus
 - b. Incidence or prevalence
 - c. How? Dual diagnosis and substance use
 - d. System response

Appendix E: List of Acronyms

ALC	Alternate Levels of Care (an assignment given to inpatients in Schedule 1 Hospitals when they are identified as no longer requiring acute care inpatient treatment, but cannot be discharged/do not have an appropriate discharge environment)
CAMH	Centre for Addiction and Mental Health
CHC	Community Health Centre
CNSC	Community Networks of Specialized Care
DD	Dual Diagnosis
DSTO	Developmental Services Toronto
ER	Emergency Room
HSJCC	Human Services & Justice Coordinating Committee
LBGT	Lesbian, gay, bisexual, and transgender
LHIN	Local Health Integration Network
MCSCS	Ministry of Community Safety & Correctional Services
MCSS	Ministry of Community and Social Services
MCYS	Ministry of Child and Youth Services
MHASC	Mental Health Alternatives to Solitary Confinement
MHJN	Mental Health and Justice Network (Toronto)
MOHLTC	Ministry of Health & Long-Term Care
MTCU	Ministry of Training, Colleges, and Universities
NADD	National Association of Dual Diagnosis
TCLHIN	Toronto Central LHIN
TNSC	Toronto Network of Specialized Care

Appendix F: List of Priorities

1. Establish a single point of contact for anything to do with Dual Diagnosis – across sectors, and for all stakeholders (individuals, families, providers). **(33 votes)**
2. Work together regionally and across/between ministries to jointly develop the strategies, pathways, and structures needed to ensure adequate resources and to operationalize coordinated delivery on the ground (with particular focus on specific interest groups such as ALC and ER Crisis, and high priority sub-populations). **(29 votes)**
3. Increased education and awareness of Dual Diagnosis services and available resources for front line workers and “up the line”, including organizational management and funders. **(24 votes)**
4. Primary care engagement and collaboration: Close the gap between Developmental, Mental Health and Primary Care Services to ensure education, participation as network partners, leadership, capacity building, collaborate with LHINs to bring about engagement (consider role of Community Health Centres (CHCs), Inner City Health Association). **(21 votes)**
5. Develop a cross-sectoral strategy/initiative – ensuring responsive and effective frontline solutions at the individual level (including strategies to connect with individuals in need (e.g., peers). **(11 votes)**
6. Increased capacity and mandate to deliver culturally competent services and promote awareness (outreach and education) (go to families with DD kids and in schools before individuals fall off the edge at age 18-21). **(5 votes)**
7. Operationalize policy so there is frontline education and communication in all sectors (the front doors), money invested into new service (cost sharing strategy) – justice, health, MCS. **(4 votes)**
8. Better support/involvement/resources for caregivers (all supporters) with connections/training across sectors (broaden community of support and connection for caregivers) inclusive circles of care. **(3 votes)**
9. Education for all sectors and research and best practice guidelines/adapted approaches for DD population with substance use/abuse issues (including issues of access to programs currently offered through the Addictions Service Providers). **(2 votes)**