JOINT REVIEW OF THE EMERALD UNIT AND THE COMMUNITY OUTREACH ASSESSMENT SERVICE TEAM (COAST) NOVA SCOTIA HOSPITAL

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&

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EXECUTIVE SUMMARY

The reviewers would like to recognize the openness and candor with which this review was met. We were extremely impressed by the staff dedication and commitment both to the individuals and to learning more to support the individuals with dual diagnosis.

We were impressed with the progress that has been made in recent years in program cohesiveness, interdisciplinary communication, assessment and measurement of progress, the reduction of the use of restraint and confinement, the rational for sedation, the efforts at team building and educational opportunities, and the commitment to building a multidisciplinary team (addition of a psychologist) that is connected and part of an active community partnership. *Our discussions showed that the program enjoys considerable respect from the agencies that were interviewed.* Much progress has been made in all areas listed above.

Goals not complete

These programs are however in a Dual Diagnosis Catch 22. Persons who are diagnosed with intellectual disability and who present with severe emotional and behavioural challenges (dually diagnosed) provide unique challenges for both the intellectual disabilities sector and mental health system. There are many reasons that create unique challenges, in addition to the clinical presentation. Griffiths & Gardner identified three specific challenges:

First, services are often inflexibly regulated within various independently operating systems (mental health, mental retardation/developmental disabilities).

Second, programs are typically directed toward a single sector interest (i.e., developmental disabilities, mental illness).

Third, expertise and clinical approaches are traditionally developed in regard to a particular discipline or specialization (i.e., psychiatry, behaviour analysis, medicine, communication training, socio-sexual training). Within these disciplines, professionals develop their areas of expertise and a professional comfort zone in that expertise. For many professionals, varying from that comfort zone is seen as moving out of one's realm of knowledge. Additionally, professionals within different disciplines develop an interdisciplinary communication system that other disciplines are unable to decipher. The result of these cross-sectorial challenges is that the person with a dual diagnosis (both mental health and developmental needs) is not appropriate for either sector yet needs the expertise of both sectors.

Disciplines use different language

These cross-sectorial and disciplinary challenges create natural barriers for services for persons with dual diagnosis, however the current situation has become road-blocked in a unique and extreme where the unit and the community team can not longer meet their ultimate objectives in light of the financial and political constraints that currently dominate the program.

The inpatient unit has become a long term holding unit for many of the 19 residents, who

no longer need this service. It was estimated that approximately 50% of the population of this program are being hospitalized without justification and some are being held against their wishes in a locked psychiatric unit, despite a lack of grounds on which to currently retain them. The individuals are being confined without justification because no community options are available for them within the system. There is a need for a variety of community options designed to support specific needs. This would include congregate living settings for individuals with significant behavioural challenges. Consequently, these individuals are living in a more restrictive environmental setting than is needed, appropriate, or advisable, because of a moratorium on placement development in the Department of Community Services. This moratorium has apparently been ongoing since 1999 under a Revitalization Initiative. The delay of discharge at this time appears to be strangling the current unit in its attempt to serve the existing population and verging on violation of the Rights and Freedoms of the individuals long time destined for release.

Relative to the inpatient unit, the current bottleneck has created a situation where the natural flow-through of individuals in the acute unit has ceased. This has created a feeling of hopelessness for the individuals who live in the unit and who have responded positively to treatment. It has however also had a very negative effect on the staff in the unit. Despite the amazing efforts that were noted above regarding administrative improvements, staff still reported feeling demoralized regarding their roles and outcomes. There was a concern for isolation, recognition of value and lack of commitment to full team involvement and communication. The stagnation on the unit appears to be felt and expressed as a lack of recognition and value.

Two additional overarching issues emerged throughout the discussions. First there is a hunger for education in dual diagnosis from almost every sector. This must be a priority for all members of the unit and the team. Second, although the unit and community team strive to develop a comprehensive biopsychosocial model of service there are challenges in understanding and clarification of roles, and integrating functions. As well, to develop a comprehensive biopsychosocial model important disciplinary gaps, such as applied behaviour analysis, speech and language etc. are missing.

The review was organized in terms of the defined goals of the program. Some of the recommendations that will be forthcoming can potentially be achieved in a short-term basis and achievable within or by mere extension of existing programming. Other recommendations are more visionary and require significant systemic changes that may take somewhat longer to achieve.

SHORT TERM RECOMMENDATIONS

The program is struggling to evolve as a team rather than as discrete individuals or as discrete disciplines. Although in previous years there have been some great strides in this area such a process takes time. The evolution into a true interdisciplinary biopsychosocial team will require additional effort and resources, team building, philosophical shifts and a commitment to a culture of mutual respect between staff and with the clients that are

supported. In addition there needs to be recognition of the apparent differences between the unit and the outpatient team to ensure there are equalized and enhanced opportunities for involvement, training, recognition and support.

With regard to current clinical operations there is a need to continue to address and expand a commitment to developing a system of accountability and evaluation of the existing program. With the retirement of the current Program Manager there is a need to re-evaluate the function of that position and expand that position to two or more functions: administrative, behavioural support, and staff educator.

VISION

Short-term recommendations for the program are only immediate solutions to current hotspots. They represent problem-stopping not problem-solving. The current system needs to be refined.

The entire system needs to be redefined in terms of the standards of care approved by the Department of Health. The philosophy of support and care should be shifting to be more person-centered and community oriented. Treatment supports must continue to move towards the least restrictive and most normative approach. As a result a systemic shift will be recommended that will reallocate resources to satellite teams that can provide comprehensive biopsychosocial consultation throughout the province. This satellite approach can provide both direct team support and expert support through mentoring and ongoing teleconferencing to local teams. The reliance on acute beds will be limited to only acute and short term treatment and should be redefined in contractual arrangements with agencies and with the Department of Community Services. The model will move actively to be proactive, preventative, educative, and focused on improvement of quality of life, rather than just the reduction of symtomotology. This dual diagnosis model for the province would move the approach from a mental illness model to a wellness model and position the program/unit to be the provincial centre of excellence in Dual Diagnosis.

RECOMMENDATIONS TO MEET GOALS OF PROGRAM

GOAL 1 To implement a continuum of mental health services that will meet the needs of individuals with a dual disorder of developmental disability and mental illness and will provide appropriate supports to individuals, families and care providers.

1a: The Department of Health, the Department of Community Services and the hospital administrators need to be made aware of the high prevalence of mental disorders/ behaviour challenges in individuals with intellectual disability. This can be accomplished by personal contact and presentations.

1b: There is an urgent need for the Department of Health to meet with the Department of Community Services to develop a short term strategy to deal with the confinement of individuals unjustifiably in the Emerald unit.

1c : There is a need for a long term plan to ensure that future gridlocks do not occur in the system. The two departments need to develop a coordinated plan that will ensure that a policy is created that will not result in a loss of "home" for persons who experience a mental health crisis, that "categorization of the clinical needs of people" does not obviate the importance of placement of persons based on a person-centred transition plan; and that the requirement for the least restrictive and intrusive environment is not blocked for persons ready for community reintegration to their own home, when the crisis has been appropriately managed.

1d: The individuals being maintained in non-acute care status on the unit need access to enriched day programming, leisure opportunities and community access, including their families. The department of community and social services should be petitioned for support to enhance the lives of these individuals until such time as they are relocated to appropriate community services. Occupational therapy could take the initiative for this on behalf of the service and persue vocational opportunities etc.

1e: The coast program is under-funded. The coast program is responsible for services for persons who have a dual diagnosis across the entire province of Nova Scotia. The team is seriously short-staffed. There is a need to revisit the operation of the program to enhance the programs opportunity to expand their efforts throughout the province.

1f: The program manager role should be able to focus solely on program administration and building a team where each member feels supported, respected and valued. The other roles currently played by the program manager are vital and must be assumed by new staff positions. These roles include educator and behavioural therapist.

GOAL 2: To ensure mental health needs of the dual; disordered population are understood, recognized and responded to at the local, district/shared district and provincial level.

2a: It is suggested that the current teams be educated and empowered to become a centre of excellence for the province. Their role could be expanded from direct service only to direct service and mentoring of generic services to build a provincial strength of expertise.

2b: The province should evoke a provincial training module and the use of videoconferencing with the coast team to develop generic strength throughout the province in the area of dual diagnosis.

GOAL 3: To design a provincial model for service delivery that is client/family centered, responsive to the unique needs of the population, facilitates access to service, provides multidisciplinary expertise, is built on collaboration between all service providers and incorporates a biopsychosocial approach to care.

3a: The programs require additional staff enhancement to complete their multidisciplinary team. Currently the team is missing key members, who are vital to effective assessment and intervention for this population. Additionally, the role of current members could be enriched and redefined to maximize their opportunities to contribute to the overall support of those with dual diagnosis.

3b: It is recommended that the model of service delivery be redesigned to provide strength to existing resources throughout the region by developing base satellite teams, enhancing local capacity through access to education, mentoring and consultation services from a core base of specialists, building local strength through direct contact with base satellite teams, and developing a coordinated and integrated model for dealing with acute needs. This requires development of three base satellite teams, strengthening the core of specialized resource personnel, and changing the model of crisis management and provision of acute care support. At the present time there is a collaborative effort between QUEST, the Behavioural Support for Adults Team, and this programme. This type of collaboration provides an excellent example of how two services funded by different Departments are working collaboratively to serve a special population.

3c: The teams should move to a more integrated biopsychosocial model where disciplinary expertise is shared and coordinated into a single plan of care.

GOAL 4: To develop standards for minimal education/training for health care providers.

4a: Goal four, relating to standards for minimal education and training of health care providers, should apply equally to the health care and developmental care providers.

4b: The practice standards developed by the current team, and approved by the department of health, are consistent with best practice. The program needs the sanction

and resources to reorganize around these standards and offer training and mentorship to ensure best practice guidelines are consistently met in the province.

GOAL 5: To enhance clinical expertise of those providing leadership in the field.

5a: A staff member, trained in adult education, should be hired/reassigned the role as educator. The role of this staff member would be to develop a range of staff development opportunities within the province. The staff development opportunities should be linked where possible to educational facilities such as colleges or universities for continuing education credits or diploma/degree credits.

5b: The educator could also coordinate staff development opportunities for staff of the programs with opportunities to enhance the general knowledge of dual diagnosis across programs, services and professionals across the province. This education could be provided for the community at a reasonable fee sufficient to offset training costs. The educator's role as community trainer would serve three functions. It would achieve the needed mandate of educating the developmental and mental health professionals about dual diagnosis. It would serve to promote the programs as the centre of excellence. Lastly, it would provide a cost recovery plan for the training that would partially reduce the expenditure for staff development for the program.

GOAL 6: To educate across the continuum of care

6: The team needs to expand training for individuals, families and direct care staff as a way of maximizing the use of natural resources, ensuring maintenance and generalization of outcomes, and building a base of prevention in existing services.

Purpose of this review:

1. To examine the current operation of the programs

2. To review the standards developed by the team and make recommendations for implementation of the standards. The program has developed Standards of Care which have been approved by the Dept. of Health.

3. To identify potential areas of professional resources for the programs

4. To identify educational opportunities for the programs to meet the standards

METHOD OF REVIEW

Background documentation was forward to the reviewers prior to arrival April 24-25, 2006. This documentation included the Standards of Practice, general information about the COAST and Emerald Hall programs, and a feedback summary from families. During our visit we met with:

- ✓ the Program Manager, Beth Floyd,
- ✓ the Health Services Manager, Marilyn Johnson,
- ✓ Drs. Tomlinson, Riives, Wood and Mershati
- ✓ COAST RNs Amy Giffin and Patricia McKay
- ✓ Occupational Therapist, Jenna MacKinnon and Anita Quillan (OTA)
- ✓ Social worker, Carolyn Miller
- ✓ Dietician, Heahter Sanderson
- ✓ Acting Executive Director of Quest, Laura Arthurs
- ✓ Regional Residential Services Society, Carol Ann Brennan
- ✓ Supervisors, Highland Community Residential Services, Mary Clare MacIntosh and Sherry Murdock
- ✓ Director of the Mental Health Program and Provincial Forensic Psychiatric Program, Louise Bradley,
- ✓ Casework Supervisor, Services for Persons with Disabilities, DCS, Marilyn Aucoin.

We also conducted:

- o a staff meeting with six of the DW staff (Lauchie McInnis, Jeremy Oliver, Trent Perrott, Steven Boutilier, Karen Sheridan, Margaret Hood and Dennis Manuge)
- o a staff meeting with the registered nurses (Deborah McInnis, Cindy Riggs, Heather Scott and Trish Berrette) and the nursing team leader, Christine Condran, and
- o a parent/family meeting with seven parents (Heather Dempsey, Janet Dion, Tracey Meisner, Keith Louden and Adele McSorley, Shirley Murphy, Tom and Rose Smith..

We also observed a consultation with Dr. Tomlinson in the community, observed the day program and the program on Emerald Hall.

Finally we conducted a summary meeting with many of the representatives from the various staff disciplines in the COAST and Emerald Hall program and the Director of Adult Mental Health for the Nova Scotia Department of Health.

THE REVIEW

Background

The current evaluation involved two related yet distinct programs that serve persons with intellectual disabilities who have emotional or mental health needs. The programs include an in-patient unit of 19 beds (Emerald Hall) and a provincial outreach component called COAST [Community Outreach Assessment Service Team].

Dual diagnosis (emotional or behavioural challenges or mental illness and intellectual disability) is a coexisting condition that occurs in approximately 1/3 of all persons with intellectual disabilities. Some of the co-morbid conditions to the intellectual disability are situational (response to death of a family member or an abuse) or transient (depression that was effectively treated), cyclical (SAD) or chronic. Often the nature of the co-morbid condition and its origin are impossible to identify from the topography of the behaviour alone. The same behaviour can be the presentation of a medical problem, abuse or loss, psychiatric condition, a reaction to an environmental change or environmental stressor, or a means of personal control in a world that may be listening to other expressions of pain or discomfort. In most cases the factors that influence a crisis are multi-factorial and typically require a thorough biopsychosocial assessment by a qualified multidisciplinary team to understand and respond to all the factors.

Dual Diagnosis Program- Stated Goals:

The stated goals of the program in keeping with the Provincial Standards are to:

- To implement a continuum of mental health services that will meet the needs of individuals with a dual disorder of developmental disability and mental illness and will provide appropriate supports to individuals, families and care providers.
- To ensure mental health needs of the dual; disordered population are understood, recognized and responded to at the local, district/shared district and provincial level.
- To design a provincial model for service delivery that is client/family centered, responsive to the unique needs of the population, facilitates access to service, provides multidisciplinary expertise, is built on collaboration between all service providers and incorporates a biopsychosocial approach to care.
- To develop standards for minimal education/training for health care providers.
- To enhance clinical expertise of those providing leadership in the field.
- To educate across the continuum of care.

REVIEW OF PROGRAM OPERATIONS RELATIVE TO STATED GOALS

The program will be discussed relative to each of *their* stated goals:

GOAL 1-

To implement a continuum of mental health services that will meet the needs of individuals with a dual disorder of developmental disability and mental illness and will provide appropriate supports to individuals, families and care providers.

The program offers two services which on the surface appears to meet the initial goal. The COAST program consists of two registered nurses and a psychiatrist; they provide community supports for individuals, families and care providers while the Emerald Hall program offers the additional crisis and treatment option for acute care for this population. The Emerald Hall Program and COAST Program have several related but distinct challenges in meeting their desired goal that relate to service capacity.

The Emerald Hall Program

The inpatient unit was designed as an acute short term treatment unit to provide support for the entire province in cases of emergency. However the program has an occupancy rate of 100% and reports that over 50% of the clients have been ready for community reintegration placement at various levels of care for many years. There appears to be three reasons for this roadblock.

1. The individuals who are admitted to Emerald Hall typically lose their community placement because of the absentee timelines that are currently in operation within the Community Services. If individuals do not return within the prescribed number of days then their placement is lost and their return to the community would be dependent on a new placement.The facility can also refuse to allow the patient to return to their "home" in the community following a hospital stay. This decision can be arbitrary depending on the willingness of the staff to tolerate challenging behaviour. In addition the decision of the placement officer can over rule the recommendations of the treating psychiatrist and team.
2. The community residences operate on a category system. If a person experiences an acute mental health problem their category of support might change and they would therefore not be able to return to their "home" in the community because that previous community option was funded under a different category of support. The individual would then have to wait until a new placement was created or found at the appropriate categorization level.
3. While both of the above policies within the Department of Community Services are contributing factors to the current bottle-neck and of great concern to the reviewers with

regard to the nature of care for someone who has experienced a mental health challenge, the most intractable barrier to the return of well persons with dual diagnosis to the community is the current moratorium that is placed on the development of new community options. The moratorium in the Department of Community Services was apparently implemented 6 years ago while the Department engaged in a reformation process. There is a significant need for day programs in the community.

The resultant effect of the current Department of Community Services polices is that the acute short term capacity of the unit operated by the Department of Health has been eliminated, not by choice but because of a political roadblock. **This roadblock creates three critical challenges for the system:**

First, because the unit is gridlocked acutely ill clients from the community cannot gain needed treatment services. The community programs with whom we met described frustration with the lack of access to the inpatient unit when acute needs become apparent. Individuals with intellectual disabilities who show an acute mental health need are being treated by local services where appropriate, but in some cases the needs of the individual exceed the knowledge or support capacity of local resources. This unit was designed for that population, yet there are no beds available to service the community needs when they are presented. Agencies often propose a trade when they have an acute problem, but such trades create many problems. First, the trades may not be in the best interest of the person. as planning of vulnerable individuals is being reduced to filling a bed rather than planning around the needs of individuals. Second, such patient-trading is not possible because of the categorization system. Third, once a trade has happened, the person who has now moved into the unit is now gridlocked and has no where to return. The cycle continues.

Second and perhaps even more severe challenging is that many of the residents of Emerald Hall are being held without justification and against their will in a locked psychiatric hospital unit. More than 10 of the individuals currently living in the acute short term program have been ready for discharge for a very long period of time (i.e., 10 years) but have been forced to be confined in a locked psychiatric unit because of a the failure of the community to develop appropriate community supports that can support these individuals. In our discussions with the individuals who live on the unit, they spoke of their desire to someday be returned to the community, to farm in the country, to a place that would be home. These individuals are currently being confined in a highly restrictive environment without any foreseeable options for community living. STANDARD7a.7 states that individuals will be discharged from inpatient care to the appropriate community setting. Transition is facilitated through collaboration, coordination and communication between all care providers to address discharge and follow up needs for the individual. This standard is not being met.

Moreover, this current situation clearly undermines the fundamental rights of these individuals. It represents discriminatory treatment because they carry a dual diagnosis. The situation is clearly confinement without justification and cruel and unusual

punishment for behaviours which have long since resided. A nondisabled person in the province of Nova Scotia who experienced an acute mental illness and recovered would not likely be held in a locked psychiatric ward for up to ten or more years post recovery. This failure to return these individuals to a less restrictive environment is inhumane and a class action law suit waiting to happen. Further more, human rights and freedoms should be neither granted nor denied by governments (Gostin, 2000). Persons possess rights simply because of their humanity. Thus, persons with Dual diagnosis do not need to prove that they deserve certain rights. Human rights law provides fundamental protections without qualification or exception.

Third, several other clients on the unit have also been there for a very long time, and while these other individuals have ongoing or recurrent issues, they are not of a severity that would require institutionalization. One man has been living on this acute unit for 40 years. These individuals could appropriately be provided support in a community group home that had specialized training in providing services for persons with intellectual disabilities who have ongoing or long term mental health challenges. These individuals do not require hospitalization but specialized supports with knowledgeable and trained staff and specialized routines.

RECOMMENDATION 1A: THE DEPARTMENT OF HEALTH, THE MINISTRY OF COMMUNITY SERVICES AND THE HOSPITAL ADMINISTRATORS NEED TO BE MADE AWARE OF THE HIGH PREVALENCE OF MENTAL DISORDERS/BEHAVIOR CHALLENGES IN INDIVIDUALS WITH ID. THIS CAN BE ACCOMPLISHED BY PERSONAL CONTACT AND PRESENTATIONS

RECOMMENDATION 1B: THERE IS AN URGENT NEED FOR THE DEPARTMENT OF HEALTH TO MEET WITH THE DEPARTMENT OF COMMUNITY SERVICES TO DEVELOP A SHORT TERM STRATEGY TO DEAL WITH THE CONFINEMENT OF INDIVIDUALS UNJUSTIFIABLY IN THE EMERALD UNIT.

RECOMMENDATION IC : THERE IS A NEED FOR A LONG TERM PLAN TO ENSURE THAT FUTURE GRIDLOCKS DO NOT OCCUR IN THE SYSTEM. THE TWO DEPARTMENTS NEED TO DEVELOP A COORDINATED PLAN THAT WILL ENSURE THAT A POLICY IS CREATED THAT WILL NOT RESULT IN A LOSS OF "HOME" FOR PERSONS WHO EXPERIENCE A MENTAL HEALTH CRISIS, THAT "CATEGORIZATION OF THE CLINICAL NEEDS OF PEOPLE" DOES NOT OBVIATE THE IMPORANCE OF PLACEMENT OF PERSONS BASED ON A PERSON-CENTRED TRANSITION PLAN; AND THAT THE REQUIREMENT FOR THE LEAST RESTRICTIVE AND INTRUSIVE ENVIRONEMNT IS NOT BLOCKED FOR PESONS READY FOR COMMUNITY REINTEGRATION TO THEIR OWN HOME, WHEN THE CRISIS HAS BEEN APPROPRIATELY MANAGED.

At this time because this program is not operating as an acute care hospital unit but as a residential holding centre, the individuals are being denied opportunities to visit with their families and opportunities for full day programming, a rich leisure programme and access to community outings. The staff indicated that there was a van and a pool but the access to these was shared with other programmes thereby limiting the time available for this unit. Families noted that they would like to have their family member visit but need support to accomplish this, however there are limited resources for appropriate natural family support. In the interim, until these individuals can be discharged to appropriate community placements there is a need to provide them with an enriched programme and access to their families and to the community.

RECOMMENDATION 1D: THE INDIVIDUALS BEING MAINTAINED IN NON-ACUTE CARE STATUS ON THE UNIT NEED ACCESS TO ENRICHED DAY PROGRAMMING, LEISURE OPPORTUNITIES AND COMMUNITY ACCESS, INCLUDING THEIR FAMILIES. THE DEPARTMENT OF COMMUNITY AND SOCIAL SERVICES SHOULD BE PETITIONED FOR SUPPORT TO ENHANCE THE LIVES OF THESE INDIVIDUALS UNTIL SUCH TIME AS THEY ARE RELOCATED TO APPROPRIATE COMMUNITY SERVICES. OCCUPATIONAL THERAPY COULD TAKE INITIATIVE FOR THIS ON BEHALF OF THE SERVICE.

The COAST Program

The program serves over 300 clients on an outpatient basis. Not all the registered cases are currently active; some are seen in a consultation program. The community and family contacts, we had during our two day visit, overwhelmingly justified the urgent and ongoing need for this service. The community program enjoys a very positive reputation in the community and with families. However three overarching challenges face the COAST team in achieving their objectives:

Fist, they are centrally based in Halifax and as such access in outlying regions require extensive travel and minimize contact. The connections with community generic services have not been developed extensively and as such the COAST program represents the only service that can help in difficult situations, yet it is limited by resources and location.

Second, the resources available to provide the provincial resource in dual diagnosis for over 300 persons are too few and there are several important gaps in the professional services provided. There is no behaviour therapist, dietician nor access to speech and language, physiotherapy, or a staff educator. The social worker is only part-time, even though the requirement is for a full-time person, and there is a need for additional nursing resources.

Best practice would suggest that caseloads for this population should be smaller and of open, flexible or long- term duration to allow sufficient contact with the service recipients

for a relationship or partnership to be developed. The relationship is vital to overcome the barriers that interfere with these individuals previously being serviced by traditional models. Additionally, an intensive relationship would provide opportunity to identify individual needs. The team should have the capacity to provide an alternative to treatment in psychiatric hospitals. The COAST team needs capacity to provide intensive case management support to a small number of fixed clients for unlimited time, as well as the provision of direct treatment, rehabilitative and support services in the natural environment through home visits, calls, and direct contact. After hours and weekend support is provided by telephone contact with Emerald Hall staff.

Third, the staff of the team reported a desire for increased education to ensure their skills were representing best practice in the field. Additionally there is a need to share the expertise within the community to build a generalized strength in understanding and services for those who may experience mental health needs. The thirst for information and education was apparent in everyone we interviewed.

RECOMMENDATION IE: THE COAST PROGRAM IS UNDERFUNDED. THE COAST PROGRAM IS RESPONSIBLE FOR SERVICES FOR PERSONS WHO HAVE A DUAL DIAGNOSIS ACROSS THE ENTIRE PROVINCE OF NOVA SCOTIA. THE TEAM IS SERIOUSLY SHORT-STAFFED. THERE IS A NEED TO REVISIT THE OPERATION OF THE PROGRAM TO ENHANCE THE PROGRAMS OPPORTUNITY TO EXPAND THEIR EFFORTS THROUGHOUT THE PROVINCE.

The current strain on the system because of the challenges cited above has had a very negative effect on the staff in the unit. Despite the amazing efforts of the current management towards education and team building, staff from different disciplines still reported feeling underutilized, underappreciated and in some cases demoralized regarding their roles and outcomes. There was a concern for isolation, recognition of value, and lack of commitment to full team involvement and communication. The stagnation on the unit in particular appears to be felt and expressed as a lack of recognition and value and even respect.

Although the administration was actively engaging in steps to promote a protective environment, it was noted that there was a division in the unit regarding tolerance to bullying. Some staff indicated that bullying occurs on the unit and that there is reluctance on the part of some staff to report this for fear of repercussions such as shunning. Some staff reported that they feel intimidated to report what they perceived to be bullying behaviour. The issue of rights, respect and responsibility needs to a pivotal issue in staff training and in agency policy and practice.

The program is struggling to evolve as a team rather than as discrete individuals or as discrete disciplines. Although in previous years there have been some great strides in this area such a process takes time and we commend the management for the work that has

been done. However the evolution into a true interdisciplinary biopsychosocial team will require additional effort and resources, team building, philosophical shifts and a commitment to a culture of mutual respect between staff and with the clients that are supported. In addition there needs to be recognition of the apparent differences between the unit and the outpatient team to ensure there are equalized and enhanced opportunities for involvement, training, recognition and support.

The COAST and Emerald Hall operate as unique but interrelated programs. In recent years there has been greater communication between the two programs, although there is still a need for significant improvement when it comes to individual client issues.
In the unit, despite excellent strides in recent years, there is still much to be done to create a culture of respect in the unit between different programs, staff, disciplines, and with clients. Communication is often lacking and mutuality and reciprocity are not always achieved:

- Some of the disciplines do not feel that they are given the information needed to do their job effectively. It was suggested that additional meeting times and clinical presentations are needed to ensure that the rationale and explanations for treatment changes are understood by all. For example, a brief daily meeting with nursing staff and physicians was requested.
- In addition there is a heavy reliance on part-time DW staff who may work more than a full shift on a regular basis; the lack of permanency in these positions can create dissatisfaction and high staff turnover. Some DW staff are viewed as Hired Muscle and as such the skills they learned in their professional education are not utilized.

With the retirement of the current Program Manager there is a need to re-evaluate the function of that position. The position has been filled extremely well by the current Manager. However the role of Program Manager appears to include too many vital functions: administrator, behavioural support, and staff educator. Moreover, the position clearly needs to be able to focus on the issue of building a successful team, where everyone feels respected and valued and demonstrates that in relation to the patients on the unit.

RECOMMENDATION 1F: THE PROGRAM MANAGER ROLE SHOULD BE ABLE TO FOCUS SOLELY ON PROGRAM ADMINISTRATION AND BUILDING A TEAM WHERE EACH MEMBER FEELS SUPPORTED, RESPECTED AND VALUED. THE OTHER ROLES CURRENTLY PLAYED BY THE PROGRAM MANAGER ARE VITAL AND MUST BE ASSUMED BY NEW STAFF POSITIONS. THESE ROLES INCLUDE EDUCATOR AND BEHAVIOUR THERAPIST.

GOAL TWO

To ensure mental health needs of the dual disordered population are understood, recognized and responded to at the local, district/shared district and provincial level.

Consultation and treatment services for persons with dual diagnosis involves not only the person with dual diagnosis, but the family or support persons who implement the program and operate as care-providers and program managers. The model assumes that the referred behavioural challenge is likely to be complex and involve alteration in all of the above factors if long-term change is to be achieved.

The majority of the inpatients were admitted in the unit because of aggressive/destructive and or self injurious behaviours. Grey and Hasting, 2005, reviewed a number of programs and services and concluded that these extreme behaviours in the main, were the result of social / environmental issues and only limited number was the direct by product of a distinct mental disorder. Stavrakaki at al, 2003, pointed to the fact that many individuals with intellectual disabilities were given a range of drugs involving polypharmacy. Literature seems to indicate that individuals with ID are not in receipt of all established interventions such as, applied behaviour analysis. Studies support function based interventions concurrently with pharmacotherapy. (Grey and Hastings, 2005)

Behaviour occurs in a social and ecological context. Behaviour change is an interactional phenomenon. As such change should occur within the natural context for the behaviour if effective change and generalization is to be expected. But additionally, the triggering, contributing and maintaining events to many behavioural and emotional challenges lie in the natural environment. As such these social environmental events must change in addition to or in order to support change in the behaviour of the individual.

Service in natural environment is geared toward enhancing coping with everyday life, and increasing the competencies of the natural caregivers. Force (2003) has also suggested that there is a need for individuals to integrate into existing generic services. He suggests this is both financially and programmatically beneficial.

The challenge currently is that the COAST program has the expertise in the community and no one else appears to share this interest or current skill level. This may in part be due to the lack of focus on this topic in professional training (i.e., medical school) or to an apprehension on the part of professionals regarding their own skills in this area. Either way, the solution calls for a system of education and professional mentoring that will stretch the very limited expert resources as far as they can be and build pockets of expertise in various parts of the province.

RECOMMENDATION 2A: IT IS SUGGESTED THAT THE CURRENT TEAMS BE EDUCATED AND EMPOWERED TO BECOME A CENTRE OF EXCELLENCE FOR THE PROVINCE. THEIR ROLE COULD BE EXPANDED FROM DIRECT SERVICE ONLY TO DIRECT SERVICE AND MENTORING OF GENERIC SERVICES TO BUILD A PROVINCIAL STRENGTH OF EXPERTISE.

RECOMMENDATION 2B: THE PROVINCE SHOULD EVOKE A PROVINCIAL TRAINING MODULE AND THE USE OF VIDEOCONFERENCING WITH THE COAST TEAM TO DEVELOP GENERIC STRENGTH THROUGHOUT THE PROVINCE IN THE AREA OF DUAL DIAGNOSIS.

GOAL THREE

To design a provincial model for service delivery that is client/family centered, responsive to the unique needs of the population, facilitates access to service, provides multidisciplinary expertise, is built on collaboration between all service providers and incorporates a biopsychosocial approach to care.

The range of services

Persons with dual diagnosis are often severe and persistent psychiatric service users of the mental health system (Rusiecki, 2003; Gerber and Millar, 2003). They may present with a variety of symptoms including medication issues, health problems, and various behavioural symptoms, counselling needs, challenges with living arrangements, daily living, family, finance, the law, the community, or employment. In her research, Beasley (2003) demonstrated that emergency services were less likely to be used and planned services more likely to be used when there were additional supports for the caregiver. She further found that families with *more than one caregiver* were more likely to use planned support and less likely to need emergency services. Although the research findings were inconclusive, the data would suggest that when services are provided in a coordinated manner, the need for emergency services appeared to reduce over time. There is a need for system-wide continuum of case, as well as crisis stabilization services as a means to reduce the demand for emergency and hospital services.

"Few communities have programs that provide comprehensive conjoint mental health and developmental disabilities services and therefore people with complex problems often fall through the cracks of the service delivery landscape" (Kormann & Petronko, 2003). Yet, since the 1980's the field has recognized the need for coordinated service systems for persons with dual diagnoses. These systems provide service linkage as a means to enhance coordination.

Over the past decade, and following the deinstitutionalization movement of the 70's, various provinces have struggled, through legislation, to provide answers to the immense impact that serious mental disorders cause to society. One such a tool has been the Community Treatment Order (CTO)(Trueman, 2003). This order is issued by a medical practitioner and compels a person with a serious mental disorder to comply with the treatment program. Several provinces, i.e., Saskatchewan, Ontario, Manitoba, British Columbia, Prince Edward Island and Alberta adopted such measures. Novas Scotia is currently undergoing a process to update its mental health legislation and system of care. It is imperative that such legislation takes into account the existing provision of services to the Dually Diagnosed and the recommendation presented in this report.

Traditional treatment for the dual diagnosed is fragmented, inaccessible and inadequate (Beasley, 2003). Community services must provide systemic consultation that is not

directed at changing the person in some cases, but changing the systems that support the person.. A range of service options must be available or have the potential to be created for the individual that include

- comprehensive assessment, consultation, psychotherapeutic and behavioural treatment, training and crisis intervention, and service systems advocacy;
- direct clinical services to families, children and adults including assessment and diagnosis, psychotherapy and behaviour therapy and case consultation; and
- links to existing mental health services in the community.

Gerber & Millar (2003) suggests that the range of services include:

- crisis support and on sight intervention,
- 24 hour on call service,
- medication management and therapy,
- medical issues,
- intensive continuous support that includes acute psychiatric services when needed,
- skills assessment and training, including hygiene, daily living, etc.,
- goal planning for meaningful daytime activities,
- activity therapy and recreation skills,
- counselling for client and family,
- supportive therapy,
- placement, housing and finance management,
- community development that wrap around the person, and
- weekly client contacts.

Rusiecki (2003) also suggests that the availability of a flexible fund allows case managers to access services for individuals where existing resources may not be available or appropriate.

Nature of Services

The field of dual diagnosis has advanced greatly in the past two decades. There is recognition and new understanding of how persons with developmental disabilities may present mental health symptoms. In recent years there has been a wealth of literature on clinical approaches to behavioural support, psychopharmacological treatment and socio-ecological intervention for this population. The current thinking is that any clinical approach must be biopsychosocial in nature. A comprehensive biopsychosocial assessment is completed to identify the multiple variables that can influence emotional health and behavioural changes. The assessment process involves the client, family and caregivers and supports client participation to the best of their ability.

Current practice in working with persons with developmental disabilities who have mental health challenges would take a holistic approach. However, the value of comprehensive behavioural assessment is vital in understanding the conditions under

which the behaviours are more or less likely to occur and the factors that serve to maintain the behaviour. Baker, Blumberg and Freeman (2004) suggest that current behavioural assessments could be adapted to evaluate the role that psychiatric illness may play in presenting a behavioural symptom. They suggest, for example, that physiological arousal may be seen as an antecedent event for problem behaviour. Gardner and Sovner (1994) caution however that physical, psychiatric or physiological challenges typically generally do not serve to trigger the occurrence of a challenging behaviour, but rather represent a vulnerability that may contribute to the behaviour in the presence of other environmental or social triggers. Typically *Functional Assessments* do not address these issues directly. However as Baker, Blumberg and Freeman (2003) suggest that adaptations to the traditional behavioural assessment could be made to expand the observations to such issues as anxious arousal, which may provide cues to the inherent vulnerabilities that need to be addressed in treatment.

The current body of knowledge would dictate that the biopsychosocial model is the standard of today's practice. However, Gardner (1998) cautions that it is not sufficient to examine the biomedical, psychological and social factors in isolation. He suggests that typically a number of factors interact to account for the "occurrence, fluctuation, severity, and persistence of most challenging behaviours of persons with dual diagnosis" (Gardner, 1998, p.63). Understanding the interplay of the factors is vital to long-term effective intervention.

The multidisciplinary team

The programs are currently staffed by:

- two nurses (outreach),
- a psychiatrist (Dr. Tomlinson) who also serves on the inpatient unit.
- a general practitioner in Psychiatry (Dr. Riives) who works on the inpatient unit under the direction of Dr.Tomlinson,
- a half time social worker (Carolyn Miller),
- a full time Occupational therapist (Jenna MacKinnon) and a full time Occupational Therapy assistant
- a full time Psychologist (Wendy Wood)
- the program manager of Specialty Services, Beth Floyd; specialty services includes the outreach and inpatient units
- a rotating team leader staff nurse on the in patient unit and four staff nurses (in patient)who rotate through as team leader role every three months
- in patient staff consisting of RNs and Developmental Workers (DWs). The DW's have either an undergrad. in Human Sciences or the two year Human Service Worker program.

Additionally, they have access to the hospital dietician (swallow disorders) and a music therapist for 1 hour a week funded by the hospital foundation/

The current team is lacking in both the range and number off professionals needed to

accomplish the task.

First and foremost, there is no applied behaviour analyst on the team. The team needs to have a minimum of two applied behaviour analysts to cover both inpatient and outpatient treatment. Applied Behaviour Analysis is a *PIVOTAL* position on the multidisciplinary team and responsible for assessing the function of behaviours and designing habilitative plans of intervention that are least intrusive. The functions of the Applied Behaviour Analyst could be complemented by specially trained Developmental Service Workers who could observe and collect data and perform in-vivo training. However this orientation of the Applied Behaviour Analyst is vital.

Second, the team appears to be in need of additional time in social work to coordinate the needed community placements and to serve as an active case manager for the active cases.

Third, Occupational Therapy would benefit from additional assistance, either in the form of an additional assistant, or the more effective use the skills of the Developmental Service Workers in planning and implementing programs. The DWs could be recruited, supported and empowered to develop a range of recreational and habilitative plans with the OT to support the individual in the natural environments. *IT IS VIEW OF THE REVIEWERS THAT THE DWS ARE CURRENTLY UNDERUTILIZED RELATIVE TO THEIR POTENTIAL SKILLS AND STRENGTHS.*

Fourth, nursing services are stretched and require expansion, particularly in the community area of Nurse Practitioner. An effective Nurse Practitioner can conduct interviews and gather background information that can greatly enhance the role of the physician or psychiatrist and minimize time spent in case analysis. A comprehensive assessment package, prepared and collected by a nurse practitioner, would maximize the valuable time of the physician and minimize potential gaps in information and diagnostic histories.

Currently there is a rotating Lead Nurse. It was noted on several occasions that this rotation can cause confusion and a lack of consistency during rotational shifts. It appears from the feedback given that the Lead Nurse should be a constant position, with the potential of a Lead Nurse assistant to serve as backup.

Fifth, access to consultations with physiotherapy, speech and language, dieticians are limited. These consultative services may be a vital piece in the habilitative program. For example a person may present with serious self injury as a result of limited ability to communicate discomfort in traditional ways; learning sign or other alternative communication could replace the use of self injury as a communication function for escape or avoidance.

RECOMMENDATION 3A: THE PROGRAMS REQUIRE ADDITIONAL STAFF ENHANCEMENT TO COMPLETE THEIR MULTIDISCIPLINARY

TEAM. CURRENTLY THE TEAM IS MISSING KEY MEMBERS, WHO ARE VITAL TO EFFECTIVE ASSESSMENT AND INTERVENTION FOR THIS POPULATION. ADDITIONALLY, THE ROLE OF CURRENT MEMBERS COULD BE ENRICHED AND REDEFINED TO MAXIMIZE THEIR OPPORTUNITIES TO CONTRIBUTE TO THE OVERALL SUPPORT OF THOSE WITH DUAL DIAGNOSIS.

The current structure of the program is heavily loaded on providing services within the unit and on a direct outreach of the experts from the Coast team. There appears to be several challenges with the existing model. First, it is difficult to provide the provincial model when the program is centralized in Halifax only. Second, the current model does not expand the base of knowledge within the province but continues to maintain the community's reliance on the already stretched resources of the current team and unit. Third, and vital to the wellbeing of the individuals with dual diagnosis, is that the existing services are loaded very heavily on service provision that is neither least restrictive nor intrusive. Fourth, the existing model is costly and yet not cost effective. Each of these issues will be addressed separately below.

Location: The program has provincial responsibility but is located in Halifax. It would appear more expedient to develop base satellite teams located in three regions of the province who can work directly with the developmental service programs and health/mental health providers in that region. The teams could be responsible for a) supporting local resources to support the individual using existing developmental and generic health/ mental health professionals where possible and b) providing consultation, assessment, intervention and crisis support within and with the local resources where needed. Although the exact composition of the teams would depend on analysis of the needs and budget, minimally each team should have a nurse practitioner, an applied behaviour analyst and developmental service worker (s). The local teams would serve to build local pockets of expertise and strength, provide proactive and early intervention, and support local resources in prevention and intervention at the time of crises in a least intrusive manner. The nurse practitioner would be able to conduct comprehensive medical histories and provide consultation and support to the agencies regarding a range of biomedical issues. The applied behaviour analyst could provide consultation, design and oversee behavioural assessments and programming. The developmental service workers would work in conjunction with the other members to implement programming within the agencies, teach direct care staff in habilitative programming, run habilitative groups (i.e. social skills, anger management) as designed by the behaviour analyst, and conduct observations. In addition, the team could work to support an agency at a times of crisis: the nurse would conducted a thorough biomedical assessment and work with the medical professionals, the behaviour analyst would conduct the functional analysis and develop a stimulus control crisis plan, and the developmental service workers could support the staff or family in the natural or alternative community environment to avert or respond to the crisis in a manner that is least disruptive to the emotional wellbeing of the individual.

The core program should remain in Halifax, although Halifax should also have the same type of base team as the other satellites. The core team would resource the whole province and the three satellite teams. The core team would include specialized resource personnel, either on a full time or contract basis, that could be accessed by the satellite services on a need basis either directly or through videoconferencing. This would include psychiatry, family medicine, occupational therapy, social work, psychology. Additional resource personnel that are needed either on a full or contract basis are physiotherapy, speech and language, neurology and genetic counsellors.

The administration of the teams would remain in Halifax. The administrative team would be responsible for developing provincial educational initiatives. The unit would still remain in Halifax, but may be able to be reduced to 10-12 patients if a more localized prevention, intervention and crisis support approach is used.

Expanding the base of knowledge within the province: As mentioned earlier the current model maintains the community's reliance on the already stretched resources of the current team and unit. The new approach based on education and local consultation would decentralize the resources and begin to build local strength in working with persons with dual diagnosis. Access to the specialized resources as consultants to other professionals, the use of videoconferencing and the expansion of educational opportunities would help to build a strong infrastructure within local communities to deal with most needs, and still allow back up to the province for more significant challenges. The experts in the province will be able to serve a broader role as provincial trainers and consultants, in addition to working on the most challenging.

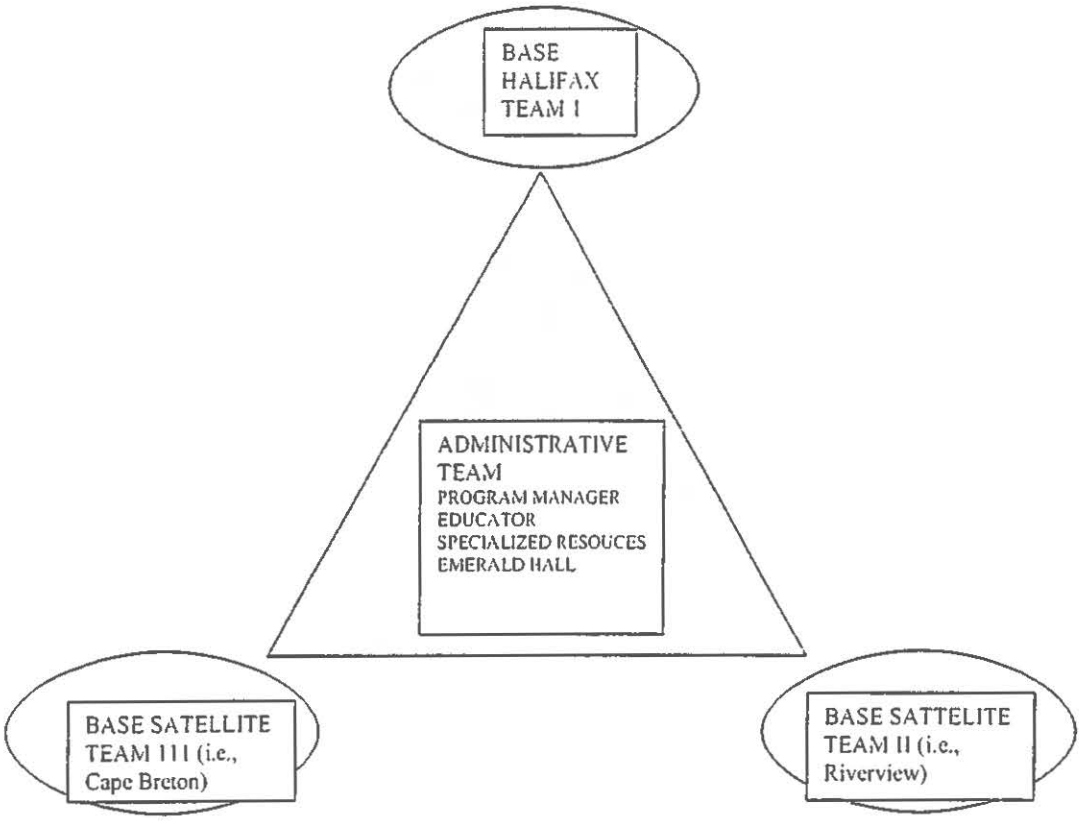
Providing services that are least restrictive and least intrusive: Building strengths in the local resources also provides services for the individuals within their home. It should serve to be proactive in prevention and early intervention of serious emotional and behavioural challenges and can allow for crisis support and intervention within the person's natural community and home. It will be less disruptive to the life of the individual and will serve to ease their discomfort as early as possible and in a manner that is more emotionally supportive and less disorienting. Even severe crisis can often be managed effectively within the natural environments using Stimulus Control strategies. Attached in Appendix A is a copy of an article on Stimulus Control and a case example of how this was applied to an individual in response to crisis.

Cost and cost effectiveness: As mentioned earlier the current model is costly but not cost effective. Many patients are being served in the unit who do not need to be in such an intrusive and restrictive setting. Moreover, many of the challenges that initially produced the referral may have been able to be prevented or provided intervention at a local level had services been readily available.

The proposed model would potentially lead to the reduction of beds on the unit to 10-12. Although at this time, the reviewers are not recommending that the acute care beds be

decentralized, there is some merit in having local beds of up to 4 persons. This would allow the host agency to maintain a relationship with the individual by having their staff maintain a working relationship with the person while in the crisis unit and allow families to remain involved. Also a unit of 4 persons is much more highly desirable relative to staff to patient contact. However, at this time such a major change might be inadvisable at least until this phase of the model has been implemented. Further, the specialized expertise is still retained in Halifax and as such when individuals require this level of support they also require the direct support of the experts.

Therefore at this time the reviewers are suggesting the retention of the Emerald Hall unit, but once the community satellite teams are operational and as individuals are discharged and that the unit be downsized. These extremely costly institutional dollars then can be reallocated to fund the satellite units.



The new model shifts the weight of the resources. Currently the base of the resources is being spent on Emerald Hall. Our model would shift the resources from Emerald Hall into the community. The greatest emphasis of the program would now be on building community strength through education and support to existing health and developmental programs. The program would serve to support those existing resources through education, mentoring, videoconferencing with the COAST teams. Should the local initiatives need additional support a referral and direct support from the COAST team would be available within the natural environment and within their region. Access to the Emerald Hall unit would still be available, but only after less intrusive and restrictive methods have been fully attempted.

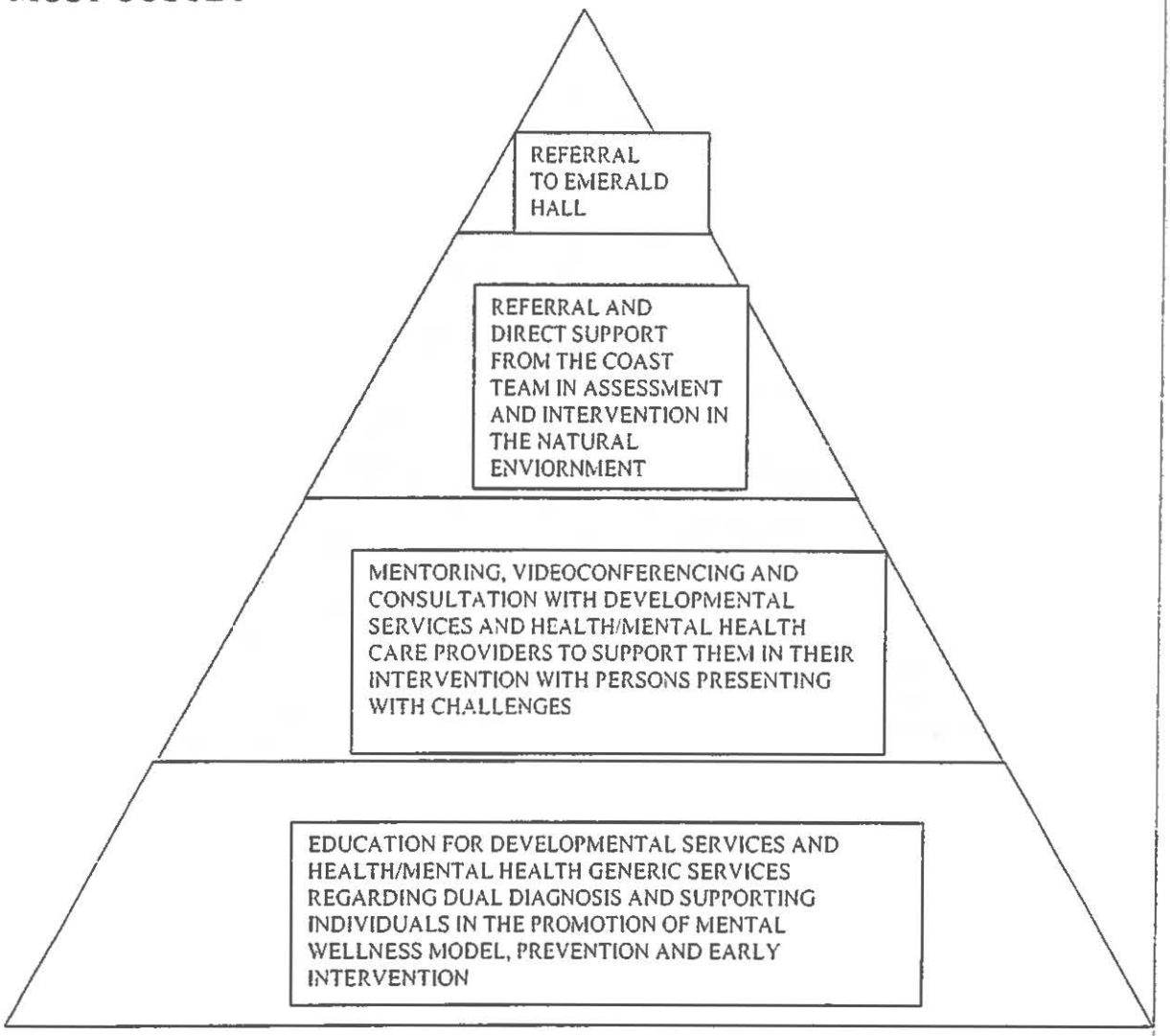
Access to Emerald Hall should be based on the recommendation from the local Satellite teams who will determine that local efforts are insufficient. However, the individual would be entering the program with an already comprehensive clinical workup by the local team and as such the transition into and through Emerald Hall should be able to be expedited. In addition, the local team could remain involved with the individual while in Emerald Hall and be responsible for coordinating with the local agency for the return of the individual after the acute stay has resolved and in supporting the individual once back in the natural setting. A contract with the natural environment should be drawn up and agreed to upon entry. The contract should delineate the approximate time that the person will stay in the unit, the responsibilities of the host agency while in Emerald Hall (i.e., contacts, training, etc.), and their role and responsibilities upon discharge. The contract will also delineate the role the Coast Team will have to support the person while in Emerald Hall and upon discharge.

This process should a) serve to resolve the expedite the time that people stay in Emerald Hall, b) provide a continuum of care and support to those having acute needs, c) ensuring a flow through with the program, and d) enhancing post acute treatment support and maintenance of progress.

RECOMMENDATION 3B: THE MODEL OF SERVICE DELIVERY SHOULD BE REDESIGNED TO PROVIDE STRENGTH TO EXISTING RESOURCES THROUGHOUT DIFFERENT REGIONS OF THE PROVINCE BY DEVELOPING BASE SATELLITE TEAMS, ENHANCING LOCAL CAPACITY THROUGH ACCESS TO EDUCATION, MENTORING AND CONSULTATION SERVICES FROM A CORE BASE OF SPECIALISTS, BUILDING LOCAL STRENGTH THROUGH DIRECT CONTACT WITH BASE SATELLITE TEAMS, AND DEVELOPING A COORDINATED AND INTEGRATED MODEL FOR DEALING WITH ACUTE NEEDS. THIS REQUIRES DEVELOPMENT OF THREE BASE SATELLITE TEAMS, STRENGTHENING THE CORE OF SPECIALIZED RESOURCE PERSONNEL, AND CHANGING THE MODEL OF CRISIS MANAGEMENT AND PROVISION OF ACUTE CARE SUPPORT. AT THE PREENT TIME THERE IS A COLLABORATIVE EFFORT BETWEEN QUEST, THE BEHAVIOURAL SUPPORT FOR ADULTS TEAM, AND THIS PROGRAMME; THIS PROVDIES AN EXCELLENT EXAMPLE OF HOW TWO SERVICES FUNDED BY DIFFERENT DEPARTMENTS ARE WORKING IN

COORDIN ATION TO SERVE A SPECIAL POPULATION.

MOST RESTRICTIVE AND INTRUSIVE
MOST COSTLY



LEAST INTRUSIVE AND RESTRICTIVE
LEAST COSTLY.....GREATEST IMPACT FOR THE DOLLAR

Multi-disciplinarity and the Biopsychosocial Model

The standard in the field of dual diagnosis is the integrated biopsychosocial (multimodal) model as developed by William Gardner. The application of this model involves more than input from different modalities but the integration of the information from each modality into an integrated and comprehensive plan that includes biomedical, psychological and social factors and the interplay of influence of those factors. This model allows for the sharing and cross-fertilization of expertise, coordination of care in a holistic way, and an integration of expertise and service delivery. While it was evident that the team had many of the expertise related to the different modalities in place, the different professionals were generally working as unidisciplines without interdisciplinary consultation and coordination. Thus the expertise was still being maintained within professional silos and there appeared to be little interdisciplinary team work.

Rather than reiterate the model and the need for multi-disciplinarity for this population, the reviewers have included a copy of the book Dual Diagnosis. The reader is referred to Chapter by Griffiths and Gardner on The integrated biopsychosocial approach to challenging behaviour and to the chapter by Summers et al. on the Inderdisciplinary Mental Health Team.

RECOMMENDATION 3C: THE TEAMS SHOULD MOVE TO A MORE INTEGRATED BIOPSYCHOSOCIAL MODEL WHERE DISCIPLINARY EXPERTISE IS SHARED AND COORDINATED INTO A SINGLE PLAN OF CARE.

GOAL FOUR

To develop standards for minimal education/training for health care providers.

Staff from developmental services who desire to work with persons who are dually diagnosed must become familiar with the assessment and intervention literature regarding mental illness mental health professionals require training in the area of developmental disability in order to bridge the discipline gap. Physicians often feel inadequately prepared to diagnosis and treat persons with dual diagnosis; service recipients and their support network agree. Most medical schools, except those with university-affiliated programs in dual diagnosis, offer inadequate or poorly coordinated educational opportunities for medical students. Finding physicians trained to work with this population is very difficult. Thus it is extremely important that the program be able to share its expertise throughout the province in a way that shares the information so that others can begin to fill the gap. The COAST team is well sought after and well regarded but their professionals can only do so much. There is a need to share the expertise with professionals in both sectors through training events, mentoring strategies and consultations to expand the infrastructure of both systems to support persons with dual diagnoses within their natural communities, where possible.

In response to the lack of physician training in the area of intellectual disabilities and dual diagnosis, the American Psychiatric Association (King et al, 1995), has included in its training: definitions and epidemiology of mental retardation, the historical and modern context of psychiatry in mental retardation, patterns of care and the changing role of community psychiatrists, legal issues, biomedical aspects of mental retardation and biomedical evaluation, and clinical approaches to assessment, treatment and intervention.

RECOMMENDATION 4A: GOAL FOUR, RELATING TO STANDARDS FOR MINIMAL EDUCATION AND TRAINING OF HEALTH CARE PROVIDERS, SHOULD APPLY EQUALTY TO THE HEALTH CARE AND DEVELOPMENTAL CARE PROVIDERS.

The Department of Health has approved the practice standards developed by the Emerald COAST team in collaboration with other stakeholders across the province (Appendix B). These present as a very good outline for service standards for this population. However practice standards are meaningless unless implemented. As a result there needs to be a provincial wide training initiative to ensure that all health care providers are provided with training in the standards as well as the basic skill set and access to mentorship with the COAST team to be able to implement these standards. The use of certification programs, standards for continuing education activities and journal clubs provided by expert local and invited guest speakers would ensure highest level of expertise and maintenance of the already acquired specialized skills.

what we are studying now ?

In Ontario, for example, the Ministry of Community and Social Services and the Ministry

of Health, collaborated with NADD Ontario (Habilitative Mental Health Resource Network) to develop a training manual and training slides and provincial access to training for all in the area of dual diagnosis. This manual and a copy of the slides have been included in this package. A similar collaborative provincial initiative could be forthcoming in Nova Scotia to ensure basic understanding of the issues of those who have a dual diagnosis and access to information on best practice.

In addition many sectors are currently working on other practice standards in dual diagnosis and in health care for persons with intellectual disabilities for nurses and doctors. A copy of the former Guidelines for Practice for Dual Diagnosis by Gardner, Dosen, Griffiths and King (2005) is attached in Appendix C. A copy of the latter training can be obtained from Dr. Thomas Cheetham from Queens University, Kingston, Ontario.

RECOMMENDATION 4B: THE PRACTICE STANDARDS DEVELOPED BY THE CURRENT TEAM, AND APPROVED BY THE DEPARTMENT OF HEALTH, ARE CONSISTENT WITH BEST PRACTICE. THE PROGRAM NEEDS THE SANCTION AND RESOURCES TO REORGANIZE AROUND THESE STANDARDS AND OFFER TRAINING AND MENTORSHIP TO ENSURE BEST PRACTICE GUIDELINES ARE CONSISTENTLY MET IN THE PROVINCE.

GOAL FIVE

To enhance clinical expertise of those providing leadership in the field.

In order for the teams to truly become the provincial Centre for Excellence in Dual Diagnosis, the team needs to have the opportunity to expand their own skills to a point of enhanced comfort. Team members of all disciplines asked for training to enhance their clinical expertise so that they were in a more positive position to assume leadership in the field. However the current budget has only minimal funds available for staff development.

Some of the challenges to providing staff development across the disciplines is a) course or conference costs, b) costs of travel and accommodations, c) cost of replacement staff. Training funds need to be made available; however the reviewers understand that these costs can be astronomical. As such it is recommended that in order to maximize the opportunity for the maximum number of staff members to develop their clinical expertise that a range of educational opportunities should be offered within the province of Nova Scotia. The program could host educational events where special speakers who are from the province or who are invited to the province would speak on topics related to dual diagnosis. It may also be possible to link the educational events to continuing education programs offered through colleges and universities so that course credit towards degrees or diplomas may also be simultaneously obtained.

Started?

RECOMMENDATION 5A: A STAFF MEMBER, TRAINED IN ADULT EDUCATION, SHOULD BE HIRED/REASSIGNED THE ROLE AS EDUCATOR. THE ROLE OF THIS STAFF MEMBER WOULD BE TO DEVELOP A RANGE OF STAFF DEVELOPMENT OPPORTUNITIES WITHIN THE PROVINCE. THE STAFF DEVELOPMENT OPPORTUNITIES SHOULD BE LINKED WHERE POSSIBLE TO EDUCATIONAL FACITLIES SUCH AS COLLEGES OR UNIVERSITIES FOR CONTINUING EDUCATION CREDITS OR DIPLOMA/DEGREE CREDITS.

* Dal Smu main ?

RECOMMENDATION 5B: THE EDUCATOR COULD ALSO CO-ORDINATE STAFF DEVELOPMENT OPPORTUNITIES FOR STAFF OF THE PROGRAMS WITH OPPORTUNITIES TO ENHANCE THE GENERAL KNOWLEDGE OF DUAL DIAGNOSIS ACROSS PROGRAMS, SERV ICES AND PROFESSIONALS ACROSS THE PROVINCE. THIS EDUCATION COULD BE PROVIDED FOR THE COMMUNITY AT A REASONABLE FEE SUFFICIENT TO OFFSET TRAINING COSTS. THE EDUCATORS ROLE AS COMMUNITY TRAINER WOULD SERVE THREE FUNCTIONS. IT WOULD ACHIEVE THE NEEDED MANDATE OF EDUCATING THE DEVELOPMENTAL AND MENTAL HEALTH PROFESSIONALS ABOUT DUAL DIAGNOSIS. IT WOULD SERVE TO PROMOTE THE CENTRE OF EXCELLENCE. LASTLY, IT WOULD PROVIDE A COST RECOVERY PLAN FOR THE TRAINING THAT WOULD

PARTIALLY REDUCE THE EXPENDITURE FOR STAFF DEVELOPMENT FOR THE PROGRAM. `

GOAL SIX
To educate across the continuum of care.

An overriding theme in the review was the need for TRAINING. Persons with dual diagnosis residing in community programs are providing increasingly complex clinical profiles. As such, more sophisticated skills are required to intervene effectively with these complex challenges. There are layers of training that are pivotal to treatment and system change. These layers are training for clients, families, direct-care staff, teachers, nurses, primary care physicians, therapists, and clinicians (i.e., behaviour analysts and psychiatrists), and across sectors or disciplines.

Client-training is a pivotal part of a positive behavioural support for persons with challenging behaviour. A comprehensive assessment including a contextual analysis would lead to identification of the skills that individuals need to learn as alternatives to their challenging behaviour. Thus clinically directed training in functional replacement or equivalent skills or functional coping and self-management skills is an essential component to most multi-modal intervention plans. Additionally, daily living, money-management, vocational or community integration skills were identified as components of a holistic service plan. Thus client-training plays a vital role in habilitiative intervention and person-centered life-planning for persons with dual diagnosis.

Providing training for families and service providers offers many long-term benefits. First, the responsibility and expertise for change is developed within the natural environment, thereby enhancing programmatic success, maintenance and generalization. Second, it optimizes the use of limited professional resources.

Training of caregivers and direct care staff is also a pivotal component part an educated system; families and care providers need to be trained in mental illness, pharmacological treatments and side effects, psychiatric hospitalization and crisis support. The reviewers were extremely pleased to see the recent educational events that had been offered to parents; the feedback was extremely positive. This type of educational opportunity is an excellent proactive approach to service delivery. In addition to the medical education that has begun, positive behaviour support training should be provided to the natural caregiver so that long term support and ownership for support can be transferred to families and direct cares staff. In many behaviour training models weekly visits are made to the natural home, where care-providers are trained in social problem solving, behavioural assessment and behavioural change techniques. Role-playing, modeling and in-vivo coaching used in addition to traditional training to ensure use and generalization of knowledge to practice. The goal is to transform the natural environment into a therapeutic milieu that can support behaviour change.

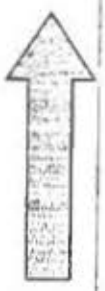
The current team does an excellent job at providing individualized support and training to individuals, families and care-providers on a referral basis. This should be continued. However a targeted proactive educational approach might reduce the demand on the individualized support demands by strengthening the expertise of the existing direct care

delivery programs. If the direct-care support in the developmental sector and the generic service delivery in mental health/health can be strengthened through education and mentoring, the existing dual diagnosis resources can be devoted to those individuals who present with more unique or extreme challenges that exceed typical resourcing.

RECOMMENDATION 6: THE TEAM NEEDS TO EXPAND TRAINING FOR INDIVDIUALS, FAMILIES AND DIRECT CARE STAFF AS A WAY OF MAXMIZING THE USE OF NATURAL RESOURCES, ENSURING MAINTENANCE AND GENERALIZATION OF OUTCOMES, AND BUILDING A BASE OF PREVENTION IN EXISTING SERVICES.

SUMMARY: The current proposal serves to accomplish several of the challenges faced by this program and those of similar programs who serve the dually diagnosed.

1. It will serve to enhance the capacity of individuals to be served in their natural environments.
2. It will build the capacity of the natural resources to support individuals with a dual diagnosis, and potentially to enhance a wellness model of support for persons with intellectual disabilities.
3. It will serve to use limited dollars in the most effective, least intrusive/restrictive and most cost effective manner possible.
4. It will enhance partnerships and inter-sectorial cooperation.
5. It will bring a continuum of care and services that will be available when needed, where needed and to the degree needed..
6. It will enhance support for families and direct care staff.
7. It will prevent and respond to crises in a new way that is least restrictive and intrusive and ensures that there is follow-up and support post crisis in the least restrictive and intrusive manner.
8. It will provide a forum to enhance provincial wide education and best practice.
9. It will provide a comprehensive and integrated biopsychosocial model of service.
10. It will build a Centre of Excellence and a mechanism for building a provincial competence in both specialized and generic resources.



April 01, 20004

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APPENDIX A:
ALTERNATIVE CRISIS SUPPORT APPROACH.

APPENDIX B: STANDARDS OF MENTAL HEALTH CARE FOR THE DEVELOPMENTALLY DISABLED POPULATION

Domains (CCHSA)	Standards Statements	Nature of Evidence
Appropriateness	E7a.1 Individualized assessment and treatment are provided in the client's natural environment whenever possible..	
Appropriateness	E7a.2 A comprehensive biopsychosocial assessment is completed to identify the multiple variables that can influence emotional health and behavioural changes. The assessment process involves the client, family and caregivers and supports client participation to the best of their ability.	
Acceptability	E7a.3 The family participates in the assessment process and may contribute to goal setting and treatment planning as appropriate	
Accessibility	E7a.4 Access to specialized assessment and treatment is available at the district / provincial level. This includes but is not limited to psychiatry, psychology (behavioural and developmental), social work, nursing, occupational therapy, speech therapy.	
Appropriateness	E7a.5 A provincial consultation service is available for individuals with complex psychiatric and behavioural issues that cannot be managed at the Local or District levels. Inpatient admission is available for individuals at the District / shared District level when required. Admission is subject to the admission criteria established for those services. Admission to subspecialty inpatient beds will be based on consultation with or assessment by the specialty team. Admission to subspecialty beds is based on the diagnosis of a psychiatric illness and the expectation that there will be some health benefit achieved from the inpatient stay.	
Efficiency	E7a.6 Admission to specialty beds for resolution or stabilization of complex mental health and co-existing problems will be conditional on an agreement with the referral agent to accept the individual back into the community when the specialty service has completed their component of the treatment process.	

Appropriateness	E7a.7 Individuals are discharged from inpatient care to the appropriate community setting. Transition is facilitated through collaboration, coordination and communication between all care providers to address discharge and follow up needs for the individual.	
Continuity	E7a.8 Established formal partnerships between health and community services facilitates collaboration in meeting the needs of shared clients.	
Accessibility	E7a.9 Individuals with communication deficits have access to augmentative communication and speech therapy services.	
Availability	E7a.10 Information describing the presentation of and treatment options for mental illness in individuals with developmental disabilities is available for families, care givers, primary care physicians and health care professionals	
Availability	E7a.11 Access to service is facilitated with the provision of information that will help people to access available services at all levels.	
Accessibility	E7a.12 Individuals with nutritional deficits have access to a full range of healthcare services including mealtime management and dysphasia assessment.	
Competency	E7a.13 Clinicians providing mental health services have education in: a) Developmental disabilities and mental illness b) non-aversive behavioural interventions	
Competency	E7a.14 Competencies that define expertise are identified through consultation with recognized experts in the field.	
Competency	E7a.15 Partnerships exist with secondary education facilities for the delivery of advanced competencies for direct care providers.	
Equity	E7a.16 A provincial network supports those providing mental health services to the developmentally disabled population. The network promotes best practice initiatives, provides leadership in defining educational needs and opportunities, provides advocacy to ensure the range of treatment options and service supports are identified and accessible. The Network promotes capacity building of service providers at the local and district levels.	
Appropriateness	E7a.17 There are processes in place to transition individuals from youth to adult services to ensure that there are no gaps in service access. .	

Appendix C

SAMPLE GUIDELINES
Manual Attached

Practice Guidelines for

Diagnostic, Treatment, and Related Support Services for Persons with Developmental Disabilities and Serious Behavioral Problems:

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